Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Gilbert Cedillo
Senator Tom McClintock
Senator Bruce McPherson
Senator Deborah Ortiz

May 21st, 2004 (Friday)
9:00 AM
Room 4203

Item	*Description*
0530	**CA Health & Human Services Agency *(Vote Only)***
4120	**Emergency Medical Services Authority *(Vote Only)***
4270	**California Medical Assistance Commission *(Vote Only)***
4280	**Managed Risk Medical Insurance Board** • **Healthy Families Program** • **Access for Infants and Mothers**
4440	**Department of Mental Health** • **Community Mental Health** • **State Hospitals *(Will be heard on Saturday, May 22nd)***
4260	**Department of Health Services** • **Medi-Cal Program** • **Public Health**

***PLEASE NOTE*:**
(1) ALL previous actions taken by the Subcommittee remain, unless the Subcommittee otherwise modifies the proposal at the May Revision hearing.
(2) The "VOTE ONLY" CALENDAR for each department may include the modification or denial of proposals, as well as acceptance of proposals. This will be noted in the Agenda as applicable.
(3) Only those issues in today's agenda are before the Subcommittee.
(4) The Subcommittee will be completely closed out at our *Saturday, May 22nd* hearing. All remaining issues will be heard at that time. Item 4300, the Department of Developmental Services will be heard on Saturday, May 22nd, as well as any remaining issues for the Department of Mental Health (State Hospitals) and the Department of Health Services, if necessary. Thank you.

I. ISSUES RECOMMENDED FOR "VOTE ONLY" *(Not in Item Order)*

A. Item 4280--Managed Risk Medical Insurance Board *(Vote Only)*

1. County Health Initiative Matching Fund (CHIM) Program

Background: The CHIM Program, established by Chapter 648, Statutes of 2001, allows county or local public agency funds to be used to match unused federal S-CHIP (State Children's Health Insurance Program) funds to provide health care for children with family incomes between 250 percent and 300 percent of the poverty level, and for parents with family incomes up to 200 percent of the poverty level. However due to delays in federal approval, the matching federal S-CHIP funds have not yet been provided to counties and local agencies. Specifically, the state submitted a State Plan Amendment in March 2003, with changes in March 2004, and we are still awaiting federal approval.

The Governor's January budget proposed expenditures of $153.8 million in funding to support potential projects from county-based initiatives as submitted to the MRMIB according to the enabling statute. Currently there are four pilot counties—Alameda, San Francisco, San Mateo and Santa Clara—who have submitted proposals that have been forwarded for federal approval. All of these counties have implemented coverage expansions for children.

Governor's May Revision: The May Revision anticipates that federal approval for CHIM will be achieved in the budget year. **However due to adjustments in local funding amounts, the May Revision proposes a decrease of $38.4 million ($13.4 million CHIM Fund and $25 million in federal funds). As such, a revised total of $115.1 million is proposed for this purpose.**

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the May Revision. No issues have been raised.

Budget Issue: Does the **Subcommittee want to approve the May Revision?**

B. Item 4120—Emergency Medical Services Authority *(Vote Only)*

1. Emergency Medical Services Terrorism Response Training

Background and Governor's May Revision: The Emergency Medical Services Authority (EMSA) **is requesting expenditure authority of $250,000 (Reimbursements** from the California Military Department through federal funds received by the Office of Homeland Security) **to hire a one-year limited-term Associate Governmental Program Analyst and fund a contract to implement a terrorism response training evaluation project and establish training standards for Emergency Medical Services responders. The contract will be for $120,000.**

The EMSA states that the resulting training standards can be used to prepare those personnel who provide emergency response to terrorism events in a manner that will protect the responders and victims. The EMSA will be working collaboratively with the California Military Department, the Office of the State Fire Marshal, the DHS and many others to identify and develop the training standards for multiple disciplines of first responders. Further they note that they will be using an existing committee established by SB 1350 (McPherson), Statutes of 2002 to provide expert advice and to assist in developing the curriculum content.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the May Revision. No issues have been raised.

Budget Issue: Does the **Subcommittee want to approve the May Revision?**

C. Item 4270— California Medical Assistance Commission *(Vote Only)*

1. Hospital Contracting

Background—Selective Provider Contracting Program: The Selective Provider Contracting Program was established in 1982. The program operates under a federal Waiver (1915 b). Through this program, the state selectively contracts, on a competitive basis, with those hospitals in California that desire to provide services to Medi-Cal recipients. The Selective Provider Contracting Program has operated successfully for almost 19 years. As noted by CMAC, competitive contracting has assured continued hospital access for recipients while at the same time, saving the state and federal governments substantial funds.

Background—CMAC: CMAC not only operates the Selective Provider Contracting Program, but also manages four other hospital financing programs in California. These include: (1) the Emergency Services and Supplemental Payments Fund (SB 1255 program); (2) the Construction and Renovation Reimbursement Program (SB 1732 program); (3) the Small and Rural Hospital Supplemental Payment Program;, and (4) Medical Education Program. Through these programs, the CMAC allocates over $2 billion (Intergovernmental Transfer Funds and federal funds)in net funds to hospitals.

As contained in statute, the CMAC consists of seven voting members and two ex-officio members (non-voting members). **The seven voting members are appointees (three by the Governor, and two each by the Senate Rules Committee and the Speaker of the Assembly), while the ex-officio members are the Department of Finance and the Department of Health Services.**

Governor's May Revision: The **May Revision proposes to provide an increase of $121,000 ($61,000 General Fund) to restore a Supervising Hospital Negotiator position which was deleted under the Control Section 4.1 process.** The CMAC states that this position will have key responsibilities in the contract negotiation process, internal office and project management duties.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the need for the Supervising Hospital Negotiator position. In addition, it is recommended to amend Section 14165.1 of the Welfare and Institutions Code to add the Legislative Analyst's Office to the membership of the CMAC as an ex-officio (non-voting) member. Due to the magnitude of funds allocated by the CMAC, as well as the complexity and importance of the state's hospital financing, the Legislature should also have a non-partisan fiscal representative serving in an ex-officio capacity.

The Subcommittee staff's proposed amendment is as follows:

> The Commission shall be composed of seven voting members and ~~**two**~~ **three** ex-officio members. The voting members shall be selected from persons with experience in management of hospital services, risk management insurance or prepaid health programs, the delivery of health services, the management of county health systems, and a representative of recipients of service. The Directors of the Department of Health Services and the Department of Finance, or their designees, **and the Legislative Analyst**, **or their designee**, shall serve ex-officio non-voting members of the commission.

Budget Issue: **Does the Subcommittee want to (1)** approve the May Revision, ***and*** **(2)** amend existing statute to include the LAO as an ex-officio (non-voting) member of the CMAC in order to have a non-partisan, legislative fiscal expert to provide oversight?

D. Item 4440 — Department of Mental Health *(Vote Only)*

1. DMH Request for Additional Staff Resources for HIPAA Implementation

Background: HIPAA was signed into law in 1996. The standards pertaining to HIPAA are still being developed by the federal HHS and involve the following:

- Privacy (covered information, covered entities, disclosures)
- Transactions (claims and encounters, enrollment eligibility)
- Code sets (diseases, injuries, impairments, and procedures)
- Unique identifiers (provider, employer, health plan, individual)
- Security (administrative procedures, physical safeguards, technical security services, and technical security mechanisms)

The DMH contracted with a consulting group—Science Applications International Corporation/Fox Systems to conduct an initial detailed assessment with respect to current practices and to assist the department in determining the course of action and changes needed to comply with HIPAA rules. The DMH states that they have met the initial requirements, but more needs to be done.

The DMH presently has 5 staff assigned to the implementation of HIPAA.

In addition, the CHHS Agency has an Office of HIPAA which is funded at $3.5 million (total funds) and has ten authorized positions.

Governor's Budget: The budget proposes **an increase of $246,000 (General Fund) to hire three more positions to be dedicated for HIPAA purposes.**

Subcommittee Staff Comment and Recommendation: **It is recommended to reject this request.** The department has 5 dedicated positions for this purpose already. Limited General Fund moneys can be utilized in other areas with higher legislative priorities.

Budget Issue: Does the **Subcommittee want to reject this request to provide an increase of $246,000 (General Fund) and three new positions?**

2. Healthy Families Program Adjustments—*Supplemental Mental Health Services*

Background: The Healthy Families Program provides health care coverage and dental and vision services to children between the ages of birth to 19 years with family incomes at or below 250 percent of poverty (with income deductions) who are not eligible for no-cost Medi-Cal. Monthly premiums, based on family income and size, must be paid to continue enrollment in the program. **California receives an annual federal allotment of federal Title XXI funds (Social Security Act) for the program for which the state must provide a 34 percent General Fund match, except for supplement mental health services in which County realignment funds are used as the match.** With respect to legal immigrant children, the state provides 100% General Fund financing.

The enabling Healthy Families Program statute linked the insurance plan benefits with a **supplemental program** to refer children who have been diagnosed as being seriously emotionally disturbed (SED). The **supplemental services** provided to Healthy Families children who are SED can be billed by County Mental Health Departments to the state for a federal Title XXI match. **Counties pay the non-federal share from their County Realignment funds (Mental Health Subaccount) to the extent resources are available.**

Under this arrangement, the Healthy Families Program health plans are required to sign Memoranda of Understanding (MOU) with each applicable county. These MOUs outline the procedures for referral. It should be noted that the health plans are compelled, as part of the required Healthy Families benefit package and capitation rate, to provide certain specified mental health treatment benefits prior to referral to the counties.

Governor's May Revision: The May Revision proposes an increase of $275,000 (Reimbursements) to reflect minor technical adjustments to the HFP supplemental mental health services. This adjustment is due to updated paid claims data and county administration adjustments.

Subcommittee Staff Comment and Recommendation: It is recommended **to approve** the May Revision.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

3. Governor's Proposal to Eliminate Funding for Sacramento County & Others

Background and Governor's Proposed Budget: The budget proposes **a reduction of $724,000 General Fund by eliminating (1)** $416,000 for supplemental funding to Sacramento County's Psychiatric Health Facility (as established in SB 840, Statutes of 1991), and **(2)** $308,000 (General Fund) used by thirteen counties to match federal rehabilitation funds.

The funds for Sacramento were originally allocated to offset the financial burden imposed on it when the UC Davis Psychiatric unit closed in 1991**. Elimination of this supplemental funding requires trailer bill legislation.**

The thirteen counties include: Contra Costa, El Dorado, Fresno, Kern, Orange, Placer, Riverside, San Bernardino, San Diego, Sonoma, Stanislaus, Ventura, and Los Angeles. All of these counties receive a total of $20,505 each, except for Los Angeles which receives $61,515

Subcommittee Staff Comment and Recommendation: It is recommended to reject the proposal, including the related trailer bill legislation.

Budget Issue: Does the Subcommittee **want to reject** the proposal to reduce county funding and the related trailer bill language?

4. Proposed Reduction of Funding for Early Mental Health Program (Prop 98)

Background—What is the Program: Under the Early Mental Health Initiative, the state awards grants (for up to three-years) to Local Education Agencies (LEAs) to implement early mental health intervention and prevention programs for students in Kindergarten through Third Grade. Schools that receive grants must also provide at least a 50 percent match to the funding provided by the DMH. Schools use the funds to employ child aides who work with students to enhance the student's social and emotional development.

Students in the program are generally experiencing mild to moderate school adjustment difficulties. Students must have parental permission to participate in the program. In addition, all Early Mental Health Initiative programs are required to contract with a local mental health agency for referral of students whose needs exceed the service level provided in this program.

The Early Mental Health Initiative is an effective school-based program. **It serves children experiencing school adjustment issues who are *not* otherwise eligible for special education assistance or county mental health services because the student's condition is usually not severe enough to meet the eligibility criteria in these other programs (such as the Children's System of Care Program or EPSDT services).**

Existing Funding Level and Grant Cycle: In the current year, **the program is supporting a total of 137 grants, with 73 grants being in their second-year of the three-year grant cycle, and 64 grants being in their third and final year of the cycle.**
According to the DMH, about 51 percent of the school sites funded through the program continue services for at least one year after the three-year grant cycle has ended.

Governor's Proposed Budget: The **Governor proposes to reduce by $5 million (Proposition 98/General Fund)** the Early Mental Health Initiative Program which provides mental health assistance to young children enrolled in school (K to Grade 3). **This proposed reduction would leave a remaining $5 million (Proposition 98/General Fund) to be used for the 73 existing grants that will be in their third year of the grant cycle beginning July 1, 2004. This funding will support about 168 actual sites.**

Subcommittee Staff Comment and Recommendation: Both the short-term and long-term effect of this reduction is that children with mild to moderate school adjustment problems will likely not receive services and may, as a consequence, need more intensive services later. Further, these students may end up doing poorly in school and developing other problems.

Therefore, it is recommended to reject the Governor's proposal. This action would provide $10 million in funds.

Budget Issue: Does the Subcommittee **want to reject** the Governor's proposal to reduce by $5 million (Proposition 98 Funds)?

5. County Costs for Incompetent to Stand Trial

Governor's May Revision: The May Revise requests a decrease of $360,000 General Fund and an increase in Reimbursements of $360,000, to reflect the impact of enacting trailer bill language that **would require County MHPs to be financially responsible for any patients in the hospitals who are deemed Incompetent to Stand Trial (IST), committed pursuant to Penal Code Sections 1372(e) and for any patients committed pursuant to Penal Code Sections 1372 (a) who remain in the hospital more than 10 days after a certificate of restoration of competency has been received by the courts.**

The Administration believes that by assigning responsibility to the counties for PC 1372 patients, the counties will have incentive to develop community-based options for patients restored to competency. However, due to the continuing stagnation of realignment revenues, it is unclear which funds counties are expected to use for this population.

Subcommittee Staff Comment and Recommendation: It is recommended to reject the May Revision because it represents a considerable departure from the existing Realignment agreements. This is just another attempt at cost shifting to the counties.

Budget Issue: Does the Subcommittee **want to reject the Administration's proposal,** to yet again, cost shift to the counties?

6. State Hospitals—Population Adjustment

Background Overall: The department directly administers the operation of four State Hospitals—Atascadero, Metropolitan, Napa and Patton--, and acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

As structured through the State-Local Realignment statutes of 1991 and 1992, the department provides hospital services to civilly committed patients under contract with County Mental Health Plans (County MHPs) while *judicially committed patients are treated solely using state funds.*

Prior Subcommittee Hearing (March 22nd): In this hearing, **the Subcommittee rejected the Governor's proposed cap on enrollment for the Incompetent to Stand Trial (IST) and Not Guilty by Reason of Insanity (NGI) patient population.** The remainder of the State Hospital population estimate was adopted pending receipt of the May Revision.

Governor's May Revision: The **May Revision proposes a net increase of $31.2 million** (General Fund) and a decrease of $933,000 (Reimbursements). **The proposed changes are as follows:**

- **Increase of $19.1 million** ($15.5 million General Fund) **for employee compensation costs** initiated in 2003-04 that were not previously budgeted by the Department of Finance. (The current year costs are included in SB 1842, the Omnibus Deficiency Bill.)
- **Increase of $11.1 million** ($15.6 million General Fund) **and 134.1 positions for staffing needs due to the projected increase in the State Hospital population.** The State Hospital population is projected to be 4,580 patients. This reflects an increase of 253 patients, or 5.8 percent above the Governor's January budget. This projection reflects the Governor conforming to the Subcommittee's action to not cap enrollment for the IST or NGI patient populations.
- **Increase of $24,000** (Lottery Education Funds) to reflect an increase in funds for educational supplies at the State Hospitals.
- **Increase of $5.940 million** (Proposition 99 Funds—Unallocated Account) to backfill for General Fund support for caseload and related adjustments at the State Hospitals. These funds became available due to adjustments in the Access for Infants and Mothers (AIM) Program operated by the Managed Risk Medical Insurance Board (MRMIB) under Item 4280.

Subcommittee Staff Comment and Recommendation: No issues have been raised by these adjustments. They reflect standard caseload and population-related adjustments. The use of Proposition 99 Funds (Unallocated Account) to offset General Fund in the State Hospital item is unusual. However, these funds became available due to reasonable adjustments in the AIM Program and are available for expenditure. Further, in the late 1980's/early 1990's, mental health programs used to receive a portion of Proposition 99 Funds for expenditure. **It is recommended to adopt the May Revision.**

7. Adjustments to Existing Mental Health Waiver for Federal Regulations

Governor's May Revision: The **May Revision requests an increase of $175,000** ($87,000 General Fund) for a contract to develop performance improvement projects and to provide training and technical assistance to County Mental Health Plans related to the implementation of new federal regulations governing the Medi-Cal Specialty Mental Health Services Consolidation/Managed Care requirements.

It also requests a reappropriation of $500,000 ($250,000 General Fund) from 2003-04 on a one-time basis for a contract to develop federally-required informing materials to Medi-Cal beneficiaries.

Prior Subcommittee Hearing (March 22nd): In this hearing, the Subcommittee discussed these new federal requirements and kept the item open pending the receipt of the May Revision.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concur with this request. In addition, the California Mental Health Directors Association has strongly indicated to DMH that extensive technical assistance from DMH to the MHPs will be needed to ensure compliance with the new federal regulations.

Budget Issue: Does the **Subcommittee want to adopt the May Revision?**

8. Early Periodic Screening Diagnosis and Treatment—Rescind Re-basing

Governor's May Revision: The May Revision rescinds the Governor's January Budget proposal to rebase (re-calculate) EPSDT provider rates. This restoration includes $60 million for the EPSDT ($60 million total funds and $40 million General Fund) and $25 million (Reimbursements-federal funds from the DHS).

Prior Subcommittee Hearing (March 22nd): The Subcommittee discussed this issue at length and had expressed grave concerns with the concept.

Staff Recommendation: It is recommended to adopt the May Revision.

Budget Issue: Does the **Subcommittee want to adopt the May Revision?**

E. Item 4260 — Department of Health Services *(Vote Only)*

1. Governor Rescinds Transfer of Non-Institutional Medi-Cal Provider Audits

Background: Medi-Cal has **about 72,000 unduplicated providers enrolled in the program to provide non-institutional services to Medi-Cal recipients.** Medi-Cal providers who demonstrate a pattern of suspicious billings are placed on utilization controls or more restrictive administrative sanctions such as withholding the provider's Medi-Cal payments. Providers placed on DHS utilization controls or administrative sanctions may ultimately be barred from participating in the Medi-Cal Program for up to ten years if convicted and in certain cases, indefinitely.

In addition to administrative sanctions the State Controller's Office (SCO) and DHS conduct audits of Medi-Cal services performed by non-institutional providers to quantify inappropriate and/or over billings to the program. The SCO has conducted audits of non-institutional services to Medi-Cal recipients since the early 1990's.

Governor's May Revision: The **May Revision rescinds the January budget proposal to transfer the responsibility for the Medi-Cal non-institutional provider audits currently being conducted by the SCO, through an Interagency Agreement (IA), back to the DHS.** Therefore, **no changes will occur** to current operations.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the May Revision to rescind (delete) the January budget proposal.

Budget Issue: Does the **Subcommittee want to adopt the May Revision?**

2. Medi-Cal 1115 Waiver Redesign Proposal—Update & State Staff Request

Background—January Proposal: Through his January budget, the **Governor proposed to seek a federal 1115 Research and Demonstration Waiver to completely restructure the existing Medi-Cal Program.** The Waiver was presented as a framework with the intent to seek stakeholder views and perspectives.

No savings for 2004-05 were identified since only a framework of ideas was proposed. However the Administration assumed savings of $800 million ($400 million General Fund) for 2005-06. No details on this cost calculation were made available since the figure was intended to be a placeholder. But it was noted that cost containment is a principal goal of the proposal.

Stakeholder Process: The Administration, in conjunction with assistance from the California HealthCare Foundation and The California Endowment, has been convening a series of workgroup meetings. **There are five workgroups which meet a total of four times between**

March and April to discuss issues and offer comments. The five workgroups include the following:

- Benefit Design and Cost Sharing;
- Program Eligibility and Simplification;
- Organized Service Delivery, including Managed Care;
- Aging and Disability Issues; and
- Financing

The Administration states that the goal of this process was to solicit input on general concepts that would be addressed in restructuring the Medi-Cal Program, and that it was not intended to produce a consensus on the Medi-Cal redesign.

Background—May Revision: Given the magnitude and complexity of the proposed redesign effort, the Administration has noted that it wants to carefully review and consider all available input and expertise before moving forward with significant, and in some cases, far-researching initiatives. **Therefore, the Administration intends to submit a Waiver proposal and legislative bill language on August 2, 2004. Their intent is to proceed forward and obtain necessary statutory changes by the end of the Legislative Session (August 30th).**

However, the Administration also states that because cost containment is a primary goal for 2005-06, if the Legislature's approval of programmatic and financing reforms is not secured by the end of the 2003-04 Legislative Session, the Administration will work with the federal government in September to secure any necessary State Plan Amendments or Waivers and return to the Legislature in January 2005 for concurrence.

Finally, it should be noted that an added component to the redesign effort is to restructure existing hospital financing with regards to intergovernmental transfer funds and disproportionate share hospital inpatient funding. Medi-Cal provides over $3 billion in supplemental funding assistance to hospitals. It is highly likely that any changes in this area will require both federal approval as well as state statutory change.

Governor's January Budget: The January budget proposed **an increase of $6 million ($2.2 million General Fund) for the DHS to (1) hire 15 new state staff**, **(2)** contract with a Mr. Charles Miller to assist the DHS in securing federal Waiver approval (a sole source contract) at $250,000 ($125,000 General Funds), **(3)** contract with EDS and Delta Dental for staff support at $1.5 million (total funds), and **(4)** contract with EDS at $2.8 million ($700,000 General Fund) for fiscal intermediary-related computer system changes.

Subcommittee Staff Comment and Recommendation: The original schedule proposed by the Administration was aggressive particularly given the complexities of modifying an entire program that services 6.7 million recipients, has a statewide network of thousands of various health care providers, and serves a diverse, medically-needy population. As such, it is welcomed news that a more deliberative process is now forthcoming.

In light of the Administration's revised schedule and the need to deliberate the Administration's forthcoming August submittal to the Legislature, **it is recommended to delete the**

Administration's proposed increase of $6 million ($2.2 million General Fund). Approval of any budgetary augmentation would be premature at this time. Any appropriation for this purpose should be considered in the context of the legislation.

Budget Issue: Does the **Subcommittee want to delete this request from the budget?**

3. Potential Expansion of Medi-Cal Managed Care—State Staff

Background-Overall: The DHS is the largest purchaser of managed health care services in California with over 3.2 million enrollees in contracting health plans. The state's Managed Care Program now covers 22 counties through three types of contract models--Two-Plan Managed Care, Geographic Managed Care, and the County Organized Health Systems (COHS). The state has federal approval to operation the Medi-Cal Managed Care Program under State Medicaid Plan authority.

For people with disabilities, enrollment is *mandatory* in the County Organized Health Systems, and *voluntary* in the Two Plan model and Geographic Managed Care model. About 161,000 individuals with disabilities are enrolled in a Medi-Cal managed care (2002 figure) plan.

In addition, **certain services are "carved-out"** of the Two Plan model and the Geographic Managed Care model, as well as some of the COHS's. **Most notably, the California Children's Services Program is "carved out", except for in selected counties which operate under the COHS model.**

Governor's January Budget—Five Staff and Contract Resources: The DHS proposes **to expand enrollment in Medi-Cal Managed Care for parents and children in an additional 14 counties that current operate under the Medi-Cal fee-for-service system. Based on DHS estimates, this expansion would transition about 414,000 Medi-Cal recipients into managed care.**

The potential geographic areas **include the following 20 counties:**

• Butte	El Dorado	Humboldt	Imperial	Kings
• Lake	Madera	Mendocino	Merced	Nevada
• Placer	San Benito	San Luis Obispo	Shasta	Siskiyou
• Sonoma	Sutter	Tehema	VenturaYuba	

The DHS notes that most of these 20 counties have service areas that have never had managed care in their counties, and that providers and hospitals may be reluctant to participate. As such, a "county cluster" approach may be used whereby three to five counties (or more) would be clustered in an effort to ensure fiscal viability for the contracting health plan.

The proposed savings are based on the assumption that the state will pay capitation rates to health plans that are equivalent to 95 percent of the Medi-Cal fee-for-service rate.

This geographic expansion would require federal approval of the state's plan (i.e., State Plan Amendment required), the execution of contracts with additional managed care health plans, and

changes to existing enrollment efforts. No federal waiver would be required for a geographic expansion

The DHS states that geographic expansions could include amendments to current contracts to add additional service areas. This process would require health plans to obtain a Knox Keene license modification by working with both the Department of Managed Health Care (DMHC) and the DHS. Geographic expansions could also occur through a competitive procurement. If a competitive procurement is done, the DHS states that implementation of a new contract would take no less than one year to execute.

The Governor's January budget proposed to increase DHS staff by five positions to implement this expansion at a cost of $400,000 ($200,000 General Fund), as well as $250,000 ($126,000 General Fund) in additional funding for a state contractor that enrolls Medi-Cal recipients in managed care plans (i.e., Health Plans Option contractor).

No local assistance savings are assumed for 2004-05 due to the time needed to develop a plan as discussed further below. However, the DHS assumes savings of $16 million ($8 million General Fund) for 2005-06 as implementation is phased-in. Annual savings of $33 million ($16.5 million General Fund) are anticipated in 2006-07.

Subcommittee Staff Comment and Recommendation: As discussed in the agenda item above, the Administration intends to submit a Waiver proposal and legislative bill language on August 2, 2004. **Further, the Administration has noted that a key aspect of any potential Waiver redesign effort is to restructure existing hospital financing with regards to intergovernmental transfer funds and disproportionate share hospital inpatient funding. These issues are critical to any substantial Managed Care expansion. Therefore, it is recommended to reject the request for these resources at this time and to instead, consider them in the fuller context of the Waiver and legislative bill package.**

Budget Issue: Does the Subcommittee **want to reject the budget proposal** to augment by $650,000 ($326,000 General Fund) and five new state staff?

4. South Central Los Angeles Regional Center (SCLARC) Waiver Funds

Background-- The Home & Community-Based Services Waiver: Over the course of the past several years, the Department of Developmental Services has been aggressively pursing receipt of additional federal funds in order to serve individuals with developmental disabilities in the community. Most notably, receipt of federal funds under the Home and Community-Based Waiver has more than doubled from 1999-2000 to 2003-04.

Under this Waiver, California can offer services to individuals who would otherwise require the level of care provided in an intermediate care facility for persons with developmental disabilities. Use of these "waiver services", such as assistance with daily living skills and day program habilitation, enable people to live in less restrictive environments such as in their home or at a Community Care Facility.

The Waiver has allowed the state to conserve General Fund dollars by shifting Medicaid (Medi-Cal) eligible consumers to Waiver services while granting flexibility and assisting the state in

complying with the Coffelt Settlement and the Olmstead Decision**.** A portion of the additional federal Waiver funds have also been used to enhance quality assurance measures, service monitoring, and several other items.

Background—South Central Los Angeles Regional Center (SCLARC): For a Regional Center to participate in the Home and Community Based Waiver, they must be certified by the state and the federal CMS. Over the course of three years, SCLARC was unable to obtain approval to enroll consumers under the Waiver. During this period the DDS provide considerable technical assistance to SCLARC to remedy certain fiscal processing concerns. The DHS, as the sole Medicaid (Medi-Cal) entity, also conducted an analysis and provided technical assistance to the DDS. (These issues and their oversight have been discussed within the purview of this Subcommittee over the past two fiscal years.).

Through these combined state efforts, the state and SCLARC obtained federal approval to lift the existing freeze on enrollment under the Waiver. Billing for *new* eligible consumers will be retroactive to October 1, 2002. Increased federal funds for this aspect of the Waiver was captured in the Governor's January budget.

Prior Subcommittee Hearing (April 19th): In addition to the federal funds identified in the Governor's January budget, the federal CMS informed California that retroactive approval for SCLARC was available back to 1999-2000. As such, SCLARC billings for consumers eligible for the Waiver can be recognized for 1999-2000, 2000-01 and part of 2002-03. According to data obtained from the DHS, a total of $29.9 million in additional federal funds is available.

The Subcommittee discussed SCLARC and the availability of these funds in its April 19th hearing. In this hearing, the Subcommittee adopted the $29.9 million as an offset to the General Fund within Item 4300, the Department of Developmental Services.

Governor's May Revision: The May Revision now identifies this same $29.9 million (federal funds) as being available to offset General Fund; however, the May Revision proposes to use this offset within Item 4260, the Department of Health Services.

Subcommittee Staff Comment and Recommendation: It is **recommended to sustain the Subcommittee's April 19th action to capture the federal funds and offset General Fund support in the DDS item.** The reason these increased federal funds are available is because the services were provided through SCLARC as a Home and Community-Based Waiver service to individuals that meet the criteria for being enrolled on this Waiver. Both the DDS and DHS provided valuable assistance to SCLARC in order for them to meet federal CMS requirements, including approval to obtain retroactive federal funding. However, the funds should be recognized within the budget Item that is responsible for providing the services.

In order to sustain the Subcommittee's prior action of April 19th, it is recommended to reject the Governor's May Revision for this issue within the DHS. It should be noted that either action saves $29.9 million General Fund.

Budget Issue: Does the **Subcommittee want to sustain its April 19th action and reject this May Revision proposal as a conforming action?**

5. Trailer Bill Language to Continue the 250 Percent Working Disabled Program

Background and Governor's May Revision Budget: AB 155 (Migden), Statutes of 2002, established the 250 Percent Working Disabled Program within Medi-Cal. This program allows working disabled persons to buy into the Medi-Cal Program. To be eligible for the program an individual must be disabled (according to federal standards), have a net income less than 250 percent of the federal poverty level (at or below $23,275 for an individual in 2004), be eligible to receive Supplemental Security Income/State Supplementary Program (SSI/SSP), and have resources less than $2,000 for an individual or $3,000 if the working disabled person is married. The program served approximately 810 individuals last year and the DHS projects an enrollment of 950 per month in 2004-05. **The enabling statute sunsets as of April 1, 2005 (Section 14007.9 of Welfare and Institutions Code).**

The Governor's May Revision contains funds to continue the program through June 30, 2005 (the end of the fiscal year).

Subcommittee Staff Comment and Recommendation: It is recommended to adopt trailer bill language to extend this important program through September 1, 2008. Trailer bill language on this issue is recommended because the funds are contained in the budget proposal and the program is set to expire during the upcoming fiscal year. In addition, it is recommended to extend the program out and establish a sunset date later in the year so a policy bill can be used to deliberate the issue in the future.

Budget Issue: Does the **Subcommittee want to adopt trailer bill language that would extend the sunset date of this important program from April 1, 2005 to September 1, 2008 (basically a three-year extension)?**

6. Proposed Reversion of Prior Year Savings in Medi-Cal & Public Health

Governor's May Revision: The May Revision **has identified $5.855 million in General Fund savings and $1.482 million in Tobacco Settlement Fund moneys (which can be used to backfill for General Fund support) which are unexpended from prior years and as such, are available for reversion. The proposed Budget Bill Language to revert these funds is as follows:**

4260-496—Reversion, Department of Health Services. As of June 30, 2004, the balances specified below, of the appropriations provided for in the following citations shall revert to the fund balance from which the appropriation was made:

0001—General Fund

(1) $2,855,000 from Program 20-Health Care Services in Item 4260-001-0001, Budget Act of 2000 (Ch. 52, Stats of 2000)

(2) $400,000 from Program 20-Health Care Services in Item 4260-001-0001, Budget Act of 2000 (Ch. 52, Stats of 2000) as reappropriated by Item 4260-491, Budget Act of 2001 (Ch. 106, Stats of 2001), and Budget Act of 2002 (Ch. 379, Stats of 2002)

(3) $500,000 from Program 20-Health Care Services in Item 4260-001-0001, Budget Act of 2001

(Ch. 106, Stats of 2001) as reappropriated by Item 4260-490, Budget Act of 2002 (Ch. 379, Stats of 2002)

(4) $2,100,000 from Program 20.10.020-Fiscal Intermediary Management in Item 4260-117-0001, Budget Act 2002 (Ch. 379, Stats of 2002)

3020—Tobacco Settlement Fund

(5) $1,482,535 from Program 20-Health Care Services in Item 4260-001-3020, Budget Act of 2001 (Ch. 106, Stats of 2001)

Subcommittee Staff Comment and Recommendation: Subcommittee staff has reviewed these reversions and concurs that the funds are available and can be reverted.

Budget Issue: Does the **Subcommittee want to adopt the May Revision?**

7. Richmond Laboratory Information Technology Support

Background: The Richmond Laboratory is a state of the art laboratory that was dedicated in April 2001. The Richmond Laboratory represents the consolidation of seven decentralized laboratories. This laboratory serves as major support for local, state and federal agencies that have public health and environmental enforcement roles. **DHS' laboratory services programs provide analytical, diagnostic, developmental, evaluative, epidemiological, reference, quality control, education, training and consultative laboratory services.**

The DHS states that the laboratories have both special needs and obligations with regard to information, data processing, and security requirements. They note that the laboratories require up-to-date information technology infrastructure and support at the Richmond campus. **They** further articulate that the laboratories will produce information and databases upon which public and environmental policy is developed and through which regulatory action is taken to protect and promote public and environmental health. Finally, they note that the research performed at this campus is also a critical component in the department's ability to respond to bioterriorism threats.

Governor's Proposed Budget: The budget proposes **an increase of $1.2 million ($424,000 General Fund, $633,000 in federal funds and $193,000 in various special funds) to purchase computer hardware and interconnect certain staff via computer connection (e-mail and the like).** It also provides access to health-related resources at the state's data centers, the internet, and connectivity to other state, federal, county, and local entities.

Specifically, the $1.250 million ($424,000 General Fund) request is for the following:

- $250,000 Network equipment
- $350,000 Servers
- $302,000 Installation and project management
- $348,000 Ongoing data center network and support

Subcommittee Staff Comments and Recommendation: Due to the lack of General Fund resources and the difficult choices regarding direct health care services, Subcommittee staff suggests to **(1) approve the request, minus the $424,000 in General Fund support**, and **(2)**

direct the DHS to review the availability of other funding sources that may be suitable for this purpose, such as other federal funds for bioterrorism, or other special funds.

Budget Issue: Does the **Subcommittee want to delete the $424,000 General Fund from the request but allow the special funds to be used ?**

8. Proposed Trailer Bill Language to Expedite Procurement Contract

Governor's May Revision: The **May Revision proposes to seek legislative approval to enter into a sliding administrative fee based contract for some activities that would supplement current state resources and potentially increase savings in the Medi-Cal anti-fraud arena.** The DHS states that there are areas that are not currently subject to the state's audit and investigations "audit for recovery" review process due to resource limitations. They contend that leveraging additional resources for performing audits, outsourcing could also expand the scope of DHS reviews to uncover unknown schemes of waste, fraud and abuse. **The DHS contends that the state would be at no risk for this contract, based on a sliding administrative fee determined by competitive bid and based on collection of funds.**

Specifically, the proposed contractors would be responsible for data analysis, onsite audits, and identification of over payments for providers such as home health agencies, dialysis, mobile diagnostic radiology, emergency and non-emergency transportation, air ambulance, as well as specialized pharmacy types like closed-door pharmacies and those providing infusion therapy services. For appeals and during litigation, they would also be responsible for providing expert testimony about the work they performed. **The DHS estimates that an additional 250 to 300 audits would be performed annually in accordance with the proposed contractual arrangements. The DHS also notes that the timeframe from the start of the legislative approval process to the awarding of the contract could take up to 18 months.**

No savings have been identified for this issue in 2004-05.

Subcommittee Staff Comment and Recommendation: The May Revision proposal on this issue is incomplete. No trailer bill language had been provided at the time of preparation for this analysis. In lieu of legislative action through the budget process, the Administration could include this proposal in their forthcoming Medi-Cal redesign package (August 2). In addition, as noted in the Subcommittee's May 10th hearing, the DHS is experiencing considerable issues regarding the timely processing of contracts. As such, further deliberation on this proposal is probably warranted.

Budget Issue: Does the **Subcommittee want to reject the proposal since trailer bill language was not provided and further deliberation on this proposal is probably warranted?** (It can be included in discussions with the Medi-Cal redesign in August if needed.)

9. Community Challenge Grants—Restore Funding

Background: The Community Challenge Grant (CCG) Program, established via the Budget Act of 1996, provides funds to local organizations to mitigate teen pregnancy and non-marital births. The CCG Program is specifically designed to reduce unwed and teen pregnancies, and absentee fatherhood through community-driven strategies and interventions implemented via a working partnership between the state and local community based organizations, local businesses, and youth and their parents.

According to the DHS, the CCG Program provides multi-faceted prevention and intervention strategies from a comprehensive array of locally determined activities and services. These include abstinence education, academic tutoring, career/job skills development, community mobilization, family life education, father's involvement, male responsibility, mentoring, parenting for teen parents, support/education for parents of teens, and youth development. The CCG Program has its second three-year funding cycle, along with one extension year (total of 7 years). For 2003-04, the current grant agreement was extended.

Governor's January Budget--Elimination: The Governor's January budget proposed elimination of the program for a reduction of $19.9 million (Temporary Assistance to Needy Families (TANF) High Performance Awards Funds).

Prior Subcommittee Hearing: In the May 3rd hearing, **the Subcommittee urged the DHS and Administration to seek funding to restore the program.**

Governor's May Revision—Restores: In his May Revision, the Administration restored full funding for the program.

Subcommittee Staff Recommendation: It is recommended to approve the May Revision.

Budget Issue: Does the **Subcommittee want to adopt the May Revision?**

10. California Nutritional Network—Increased Federal Funds

Background: In the mid-1990's, the federal USDA started strengthening the nutrition education component of the Food Stamp Program. An updated definition of nutrition education was established as "any set of learning experiences designed to facilitate the voluntary adoption of eating and other nutrition-related behaviors conducive to health and well-being", and states were encouraged to use large-scale marketing approaches. Social marketing had emerged in a USDA analysis of the nutrition education field as holding the most promise for achieving healthy eating among large numbers of people.

The California Nutrition Network for Healthy, Active Families (Network) is a social marketing campaign within the DHS. The Network is funded primarily by federal funds awarded by the US Department of Agriculture (USDA) to the California Department of Social Services. Through an annual interagency agreement, the DSS reimburses the DHS for activities conducted for the Network as identified in the USDA approved plan.

The Network qualifies for federal financial participation each year by documenting and compiling the in-kind expenditures of non-federal funds for allowable nutrition education activities to lower income households being made by state and local agencies, submitting a state plan and budget through the DSS, and dispersing the federal funds according tot he USDA-approved plan. Half is returned through local assistance contracts to contributing agencies.

Prior Subcommittee Action (May 3rd): The Subcommittee approved a Finance Letter to provide an increase of $39.7 million (Reimbursements from the DSS which are all federal funds) to reflect the receipt of increased resources. All of this increase was for local assistance.

Governor's May Revision: The May Revision

11. Health Insurance Portability & Accountability Act (HIPAA) Compliance

Background and Governor's Budget: The DHS is requesting **to extend 13 limited-term positions for an additional three-years** and to reduce the Genetic Disease Branch's special fund allocation for HIPAA activities by $1.7 million (Genetic Disease Testing Fund). These positions will be used for the purpose of complying with the published final rules, changes to those rules, and provide support to the Department's Privacy Officer in the Office of Legal Services. These positions include key leaders of the Office of HIPAA compliance. The DHS states that they need to continue staff at the current level to facilitate the implementation and maintenance of the HIPAA regulations department-wide.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the budget request.

Budget Issue: Does the **Subcommittee want to adopt the budget as proposed?**

12. Proposed Trailer Bill Language To Eliminate Flexibility in Special Fund Allocation

Background: The DHS Tobacco Control Programs, established using Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds), have been shown to be highly efficacious. **The anti-tobacco media campaigns, television ads and other anti-tobacco advertising have been evaluated on numerous occasions and have shown to be highly effective in mitigating the spread of smoking in our society, and thus, the deplorable health affects of cancer, heart disease and related illnesses.**

The Health Education Account of the Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds) is used to support the Tobacco Control Program and the various "media buys" that are done for the program. **Funds deposited in the Health Education Account are not "fungible"** to the General Fund. As a matter of practicality, for the past many years (since the mid-1990's), through the annual budget trailer bill process, the Tobacco Control program has been granted authority to roll forward unexpended Health Education Account funds. **Often times due to the nature of the media buys, funds cannot be expended by the end of the**

fiscal year but would be expended by fall. As such the Omnibus Health Trailer bill had regularly included language to account for this accommodation. **In AB 1762, the Omnibus Health trailer bill that accompanied the Budget Act of 2003, a provision was added to the language to continue this cash-flow on to future fiscal years.**

Governor's Proposed Budget: The budget **proposes trailer bill language to repeal the action taken in the Budget Act of 2003 by eliminating Section 104466 of Health and Safety Code related to the DHS Tobacco Control Program.**

Subcommittee Staff Comment and Recommendation: The Legislature's action taken in AB 1762, Statutes of 2003 was intended to continue past practices for providing appropriate funding for the Tobacco Control Program using special funds that by law, and Proposition 99, cannot be used for anything else. Further, the Tobacco Control Programs are highly effective as demonstrated by numerous independent evaluations. As such, there is no reason to repeal the action taken through last year's budget. Therefore, it is recommended to reject this proposal.

Budget Issue: Does the Subcommittee **want to reject** the proposed trailer bill language?

13. Governor's May Revision Trailer Bill Language for Inpatient Hospital Rates

Governor's May Revision: The May Revision **proposes trailer bill language that (1)** technical adjusts a provision contained in AB 1762, Statutes of 2003 (Omnibus Health Trailer Legislation for the Budget Act of 2003) regarding inpatient hospital rates for 2004-05, and (2) recognizes an adjustment needed for the state to appropriately adjust the interim rate for non-contracting hospitals. **The proposed trailer bill language is as follows:**

Uncodified Trailer Bill

(a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures.

(b) (1) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Services, the amounts paid for inpatient services provided to Medi-Cal recipients during the 2004-05 fiscal year shall not exceed the amount determined pursuant to paragraphs (3) and 4

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) The maximum payment for services provided during 2004-05 shall be calculated using the "as audited" cost per day (including ancillary costs) for the hospital's fiscal period ending in the ~~2002~~ 2003 calendar year~~, adjusted for one years' increase as reflected in the Medicare Economic Index as defined in Section 1395u(i)(4) of Title 42 of the United States Code~~.

(4) When calculating a hospital's cost report settlement for a hospital's fiscal period ending in the 2004-05 fiscal year that is subject to paragraph (1), the settlement shall be limited to the lower of either the hospital's cost per day for inpatient services provided during the 2004-05 fiscal year, or the "as audited" cost per day for the hospital's fiscal period ending in the ~~2002~~ 2003 calendar year ~~increased by an~~

~~adjustment as reflected in the Medicare Economic Index as described in paragraph (3)~~, multiplied by the number of inpatient days rendered during the 2004-05 fiscal year.

(c) Notwithstanding any other provision of law, for acute care hospitals not under contract with the Department of Health Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, the amounts paid for inpatient hospital services provided during the 2004-05 fiscal year as interim payments shall be reduced by 10 percent with respect to the interim rate on file and in effect on January 1, 2004, as established pursuant to Section 51536 of Title 22 of the California Code of Regulations. The room rates on file for purposes of Section 51536 of Title 22 of the California Code of Regulations on January 1, 2004, shall be used for the period July 1, 2004, through June 30, 2005, and requests for room rate increases shall not be processed. This section shall not affect the final settlement process or amounts as determined pursuant to subdivision (b) or Section 51536 of Title 22 of the California Code of Regulations.

~~(c)~~(d) It is the intent of the Legislature that the California Medical Assistance Commission freeze all Medi-Cal reimbursement rates paid to hospitals for inpatient services at their 2003-04 contract rate, or at a lower level, whichever is applicable based on contract negotiations.

~~(d)~~(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the Director of Health Services may implement subdivision (b) by means of a provider bulletin, or similar instruction, without taking regulatory action.

~~(e)~~(f) The Director of Health Services shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

Subcommittee Staff Comment and Recommendation: The proposed trailer bill language is needed in order to incorporate an action taken in the Budget Act of 2003 which respect to freezing inpatient rates for 2004-05 with the Governor's proposed action to reduce the interim payment made to non-contract hospitals in 2004-05. The Subcommittee did adopt the Governor's proposal to reduce the interim payments made to non-contract hospitals in the May 3rd hearing. As noted in the April 12th and May 3rd hearings where this issue was discussed, the hospitals will still be receiving their full payment once reconciliation is completed. It is just the interim payment that will be reduced (i.e., less float for the state to pay initially). **It is recommended to adopt these technical trailer bill language changes.**

Budget Issue: Does the Subcommittee **want to adopt the proposed May Revision** trailer bill language?

14. Continued Implementation of Proposition 50 by the DHS

Background on DHS' Drinking Water Program: The DHS has been responsible for regulating and permitting public water systems since 1915. **The Drinking Water Program provides for ongoing surveillance and inspection of public water systems, issues operational permits to the systems, ensures water quality monitoring is conducted and takes enforcement actions when violations occur. The program oversees the activities of about 8,500 public water systems that serve more than 34 million Californians (about 98 percent of the population).**

The DHS is designated by the federal Environmental Protection Agency as the primacy agency responsible for the administration of the federal Safe Drinking Water Act. Under

the federal Safe Drinking Water Act, California receives funding to finance low-interest loans and grants for public water system infrastructure improvements. **In order to draw down these federal capitalization grants, the state must provide a 20 percent match.** Proposition 13 bond funds had been used as the state match for this purpose in previous years. **However, the state match for future capitalization grants is now provided by Proposition 50, as contained in the Proposition. Proposition 50 bond funds are also used for additional purposes as discussed below.**

CALFED Program Relationship: The **DHS is also a participant with other state and federal agencies in the CALFED Program.** The CALFED Program, pursuant to SB 900, Statutes of 1996 was authorized to develop by means of Programmatic Environmental Impact Statement/Report a preferred alternative of programs, actions, projects and related activities which will provide solutions to water management problems in the Bay-Delta Region. The DHS' involvement relates to drinking water improvement projects.

Background on Proposition 50 and Chapters Applicable to the DHS Drinking Water Program: Proposition 50—the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002—was approved by the voters **to provide *$3.4 billion* in funds to a consortium of state agencies and departments to address a wide continuum of water quality issues.** The bond measure contains 11 chapters, or subdivisions, which delineates the funding level to be provided over the course of the bond and the activities and functions which are to be addressed. **It also contains language throughout the measure that provides authority to the Legislature to *"enact such legislation as is necessary"* to implement certain chapters.**

Several chapters within the Proposition 50 bond measure pertain to functions conducted by the DHS as it pertains to the Drinking Water Program, including Chapter 3 and Chapter 4**. The DHS anticipates receiving as much as $528 million over the course of the bond measure. This funding is discussed below.**

Background on Chapter 3—Water Security ($50 million total from bonds proposed for DHS): Proposition 50 **provides a total of $50 million for functions that pertain to water security, including the following:** (**1)** Monitoring and early warning systems; **(2)** Fencing; **(3)** Protective structures; **(4)** Contamination treatment facilities; **(5)** Emergency interconnections; **(6)** Communications systems; and **(7)** Other projects designed to prevent damage to water treatment, distribution, and supply facilities. It is anticipated that this total amount will be utilized over a four-year period.

Background on Chapter 4—Safe Drinking Water ($435 million total from bonds for DHS): Proposition 50 provides that $435 million be available to the DHS for expenditure for grants and loans for infrastructure improvements, and related actions to meet safe drinking water standards. **About $17 million will be used as the state's matching funds to access the federal capitalization grants for public water system infrastructure improvements. These state matching funds will be spent over 5 years.**

With respect to the other projects, the Proposition states that the funds can be used for following types of projects: ,**(1)** Grants to small community drinking water systems to upgrade monitoring, treatment or distribution infrastructure; **(2)** Grants to finance development and demonstration of new technologies and related facilities for water contaminant removal and

treatment; **(3)** Grants for community water quality; **(4)** Grants for drinking water source protection; **(5)** Grants for treatment facilities necessary to meet disinfectant by-product safe drinking water standards; and **(6)** Loans pursuant to the Safe Drinking Water State Revolving Fund (i.e., the existing program whereby the state draws down an 80 percent federal match).

In addition the Proposition requires that not less than 60 percent of the bond funds pursuant to Chapter 4 be available for grants to Southern California water agencies to assist in meeting the state's commitment to reduce Colorado River water use as specified.

Governor's Proposed Budget & Finance Letter Request: The **Administration proposes to provide the following funding for 2004-05 to the DHS:**

- ***For Chapter 3 Functions (Total of $10.4 million for 2004-05):*** **(1)** $10.1 million for local assistance projects, and **(2)** $262,000 for on-going state support and administration.
- ***For Chapter 4 Functions (Total of $99.8 million for 2004-05):*** **(1)** $17 million for state match funds to access federal capitalization grants for public water system infrastructure improvements, **(2)** 80.8 million for local assistance projects, and **(3)** $1.9 million for administration.

Issue of Private Entities and the DHS Draft Guidelines: The **DHS has issued draft guidelines for Proposition 50 bond funds that would allow private water agencies to compete for bond funds.** The Legislative Counsel as well as legal counsel for the DHS have issued legal opinions that contend private water agencies are eligible for bond funds. The California Public Utilities Commission regulates investor owned water utilities and mutual water companies. Traditionally, these utilities have been relatively small utilities that serve small jurisdictions. **However in recent years, larger investor owned utilities have purchased many of these small utilities.**

However, other interested parties contend that while Proposition 50 did not explicitly exclude private water companies within the text of the enabling statutory language, there is similarly no explicit inclusion of private water company eligibility either. Further, they note that the official voters guide told voters that the bond funds would be available for expenditure by various state agencies and for loans and grants to local agencies and non-profit associations. They also contend that some of the larger investor owned utilities and mutual water companies have greater access to the capital markets for the purposes of financing projects than many municipal utilities.

To-date, the other state agencies administering water-related grant programs have not published guidelines that explicitly allow private water agencies to compete for bond funds.

Subcommittee staff has been advised that the Administration is currently considering this policy issue internally.

Prior Subcommittee Hearing (May 10th): In this hearing, the Subcommittee discussed the proposal and accepted public testimony. The issue was held open pending the receipt of the May Revision. **In addition, the Chair requested the LAO to review the issue of private water agencies receiving bond funds.**

Legislative Analyst Office Report—May 2004: In a report released on May 19th, the LAO provides an analysis regarding the legal, tax, and policy issues for legislative consideration in evaluating the funding eligibility of private water companies under Proposition 50. **Based on their review, they conclude that the broad public purpose of Proposition 50 bond funds would be served by including private entities as eligible recipients of such funds.** ***That said, the LAO also identifies several significant legal, tax, and policy-related concerns regarding the use of these bond funds for private entities that they believe should be addressed by legislation.***

Subcommittee Staff Comment and Recommendation: Based on information obtained from Legislative Counsel, the LAO, and other interested parties, it is evident that legislative direction is needed regarding the complexities of the policy issue related to the state (DHS) providing bond funds to private water companies. **It would be beneficial if the DHS could delete this aspect from their guidelines until the policy issue has been more fully deliberated by the Legislature. However at this time, it is unknown if they are willing to do so. In the absence of an answer, it is recommended for the Subcommittee to adopt the following Budget Bill Language:**

> "The Department of Health Services shall not allocate funds made available by the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 to private water companies, unless legislation is passed during the 2003-04 Legislative Session that expressly allows for such allocation.

Budget Issue: Does the Subcommittee **want to (1) approve the appropriation as budgeted (January and Finance Letter), and (2) adopt Budget Bill Language that would allow for the DHS to provide bond funds to private water companies *only if* legislation which allows for this passes in the current session and is chaptered?**

15. Federal Bioterriorism—New Funds, More State Staff, and Application Coming

Background—Overall Summary: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), and subsequent federal legislation, provided states with additional federal funds to support and address both local and state concerns regarding the threat of bioterrorism.

Under this federal law there are two funding streams made available to California—one from the federal Centers for Disease Control (CDC), and one from the federal Health Resources and Services Administration (HRSA). The CDC grant is in support of state and local public health measures to strengthen the state against bioterrorism via a "Cooperative Agreement" to the DHS. The HRSA grant is for the development and implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency medical systems and related matters.

The grants require California to meet specified benchmarks and activities. As such California must submit a Cooperative Agreement application to the federal government for their review and

approval. However, California is assured by the federal government that grant funds will be provided, once the application is approved.

The DHS notes that they are responsible for detecting and responding to bioterriorism acts. Regardless of source, surveillance of infectious diseases, detection, and investigation of outbreaks, identification of etiologic agents and their modes of transmission, and the development of prevention and control strategies are the responsibility of state and local public health agencies. They also note that the ultimate responsibility for protecting the public and environmental health of the population on the ground lies with the Local Health Jurisdictions, especially during biological or chemical incidents.

CDC Cooperative Agreement Grant Overall: This grant is for upgrading the state and local public health jurisdictions' critical capacities related to preparedness for and response to bioterriorism in seven focus areas as follows: Planning and Readiness Assessment, Surveillance and Epidemilogy Capacity, Communications and Information Technology, Health Risk Communications and Information Dissemination, and Education and Training. As a condition of the funding, the DHS must meet 16 critical capacities and 25 benchmarks.

HRSA Grant Overall: This grant is focused on activities for the Hospital Bioterrorism Preparedness Program. These funds are to be used for hospitals, outpatient facilities, local emergency medical systems, and poison control centers. A needs assessment of hospitals' and clinics' capabilities to respond to a bioterriorism event has been completed and funds have been provided to hospitals and clinics for planning and preparedness activities. A Joint Advisory Committee has been established, as required by the federal government, to allocate the grant funds to local entities and to address inter-hospital and regional planning issues regarding the management of a bioterrorism incident.

Budget Act of 2003 and Administration's Section 8 Letter: Since these bioterriorism grants operate on a federal fiscal year and also require states receiving funds to summit a detailed application which requires federal approval, **the timing of the process does not neatly correspond to California's state budget cycle or fiscal year. For example, the federal government provides states with guidelines for development of the applications in mid-May. States usually have 45 days after receipt of the federal guidelines. In addition, the federal government usually makes some changes to these applications. As such, the Legislature is at risk of appropriating funds with little detail as to its potential expenditure in some cases.**

In the Budget Act of 2003, the Legislature agreed that about half of the new federal funds for the August 31, 2003 to August 30, 2004 cycle be funded in the budget and the remaining amount be appropriated through SB 678 (Senator Ortiz). **This was done in order to give the DHS ample opportunity to work with major constituency groups—Local Health Jurisdictions, County Health Officers, hospitals, and related core emergency/disaster-related response entities—on specifically how the funds were to be spent (and to correspond to the state's federally – approved applications).**

SB 678 stalled on the Assembly floor at the end of session last year due to issues unrelated to the content of the legislation, the remaining federal funds were appropriated through authority provided via the Joint Legislative Budget Committee and the Section 8 process in the Fall of

2003. However, SB 678 was just recently signed by the Governor in April 2005 so all other aspects of the legislation are now in place.

California Must Submit New Application to Obtain Federal Grant Funds: A new federal grant cycle is approaching which will require the state to submit an application for federal approval. **As with last year (as discussed above), the Budget Bill will be completed prior to the completion of the Cooperative Agreement application being submitted, reviewed and approved by the federal government.** According to the DHS, states are to receive the guidelines in **mid-May** and are then expected to submit an application to the federal government within 45 days.

Governor's Proposed Budget & Finance Letter—New Federal Funds, New Positions & Budget Bill Language Requested: The Governor is proposing **two adjustments** regarding this federal bioterrorism funding. **First, the DHS is requesting an increase of $76.5 million (federal funds) for total expenditures of $108.9 million (federal funds) in 2004-05.**

Second, the DHS is requesting an increase of 28.8 new state positions in addition to an existing base of 76 positions for this purpose. Of these total new positions, 10 are requested to be made permanent and 18.8 are limited-term (through June 30, 2005).

As noted in the table below, of the total amount, (1) $36.5 million, is for state support and related functions, (2) $47.1 million would be provided to Local Health Jurisdictions, and (3) $25.2 million would be provided for local assistance associated with the HRSA grant requirements.

Third, the DHS is seeking approval of Budget Bill Language (both in the state support item and local assistance item) that would allow for expenditure and encumbrance of these federal funds through August 30, 2006. This is one year longer than the state's fiscal year and one year past the federal fiscal year for which the funds are allocated to California. **Specifically, this proposed language is as follows:**

> "Notwithstanding any other provision of law, moneys made available for bioterrorism preparedness pursuant to this Act shall be available for expenditure and encumbrance until **August 30, 2005**."

Summary of Bioterriorism Funding for 2004-05 *(State Fiscal Year)*

DHS Proposed Budget & Finance Letter for Bioterrorism 2004-05 (State Fiscal Year)	State Support (Positions)	Local Health Jurisdictions	Hospitals, EMS & Related Entities	TOTALS
1. CDC Grant ***(anticipated)***	$23 million (76 + 18.8 positions = 94.8)	$47.1 million	N/A	$70.1 million
2. HRSA Grant ***(anticipated)***	$13.5 million (0 + 10 = 10 positions)	N/A	$25.2 million	$38.7 million
TOTAL Amounts	**$36.5 million**	**$47.1 million**	**$25.2 million**	**$108.8 million**
Baseline Amount	**($7.3 million)**	**($25 million)**	**0**	**($32.3 million)**
CDC Baseline	$6.8 million	$25 million	N/A	$31.8 million
HRSA Baseline	$488	N/A	0	$488

Requested Increase	$29.2 million	$47.2 million	$25.2 million	$76.5 million
CDC Baseline	($16.2 million)	($22 million)	N/A	($38.2 million)
HRSA Baseline	($13.1 million)	N/A	($25.2 million)	($38.3 million)

With respect to state support, the DHS contends it needs an additional 28.8 positions in addition to the base of 76 positions because (1) the federal government added more requirements, and **(2)** positions are needed to track all fiscal aspects of the grants. The DHS states that all activities outlined in the Cooperative Agreement must be performed by the recipient agency (i.e., DHS) as a condition of the CDC award. In addition, the DHS states that HRSA has added numerous benchmarks required benchmarks as a condition of funding.

Although the DHS will address some of these requirements through interagency agreements and contracts, an additional 10 permanent positions and 18.8 limited-term positions (until June 30, 2005) are needed to ensure coordinated planning and response efforts between the state and Local Health Jurisdictions.

Constituency Comments: Some constituency groups have expressed a desire to place a portion of the federal bioterriorism funds into SB 431 (Ortiz) (as amended January 5, 2004) as was similarly done last year (as discussed above in this agenda).

Prior Subcommittee Hearing (May 10th): In this hearing, the Subcommittee deliberated the issue and received public testimony. The Chair expressed his intents of addressing constituency concerns by following a similar path as last year and providing an appropriation through both the Budget Bill and a legislative policy bill.

Subcommittee Staff Comment and Recommendation: Based on the perspective of the Chair, it is recommended to **(1)** appropriate the full increase for the local assistance item as contained in the January budget and Finance Letter (i.e., $47.2 million federal CDC grant and $25.2 million federal HRSA grant), **(2)** appropriate the full increase for the state appropriation for the federal HRSA grant, **(3)** reduce the state appropriation for the CDC federal grant amount by $2.3 million so these funds can be appropriated after the Cooperative Agreement with the federal government is completed (probably in July), **(4)** adopt Budget Bill Language directing the DHS to include implementation of SB 2065, Statutes of 2002 (low-level radioactive inventory as it pertains to bioterrorism) in the state's application to the CDC, **(5)** adopt Budget Bill Language directing the DHS to provide notification to the Legislature regarding any changes the federal government makes to the state's application, including funding and policy changes (as stated below), and **(6)** adopt the Budget Bill Language proposed by the Administration (as discussed under their proposal, above).

Budget Bill Language:

> 4260-001-0001
> Provision x.
> "The Department of Health Services shall include a request for funding in the state's application for Cooperative Agreement for funding from the federal Centers for Disease Control and Prevention's Public Health Preparedness and Responses to Bioterriorism Program regarding the state's efforts to establish reporting procedures for low-level-radioactive waste as contained in Chapter 891, Statutes of 2002."

"The Department of Health Services (DHS) shall notify the fiscal and policy committees of the Legislature in a timely manner regarding the federal government's approval of the state's application for Cooperative Agreement for funding from the federal Centers for Disease Control and Prevention's Public Health Preparedness and Response to Bioterriorism Program. This notification shall include a summary of all policy and fiscal changes made by the federal government to the state's application submittal. If additional changes are made through out the fiscal year, the DHS shall so notify the fiscal and policy committees in a similar manner.

Budget Issue: Does the Subcommittee **want to adopt the Subcommittee staff recommendation, based on the Chairs direction** as provided in the May 10th hearing, as shown?

16. In Home Supportive Services "Independence Plus" Waiver—Request for Staff

Background: The DHS is the single Medicaid agency in California. As such, the DHS is involved in all aspects of developing, implementing and monitoring Medicaid (Medi-Cal) Waivers for all of the state's programs, including those programs operated by the state Department of Social Services (DSS).

The Independence Plus Waiver is a new federal waiver process intended to provide guidance and assistance to states wishing to implement programs to support the self-direction of services and supports by persons with developmental disabilities and their families. It provides states with the ability to offer individuals or families who require long-term supports and services greater opportunities to take charge of their own health and direct their own services.

Under this Waiver, California can apply for Medicaid (Medi-Cal) reimbursement for provider wage payments to the parents of minor children and spouses, advance pay to individuals who hire and train their own caregivers, protective supervision services to those who may have cognitive impairments, domestic services for those receiving personal care and related services, and restaurant meal allowances for those who have disabilities that prohibit or make unsafe meal preparation in their own home.

The May Revision is proposing to seek this federal Waiver to secure federal funding for the In Home Supportive Services (IHSS) Residual Program in lieu of the Governor's January proposal to eliminate the program operated by the Department of Social Services. Proposed legislation to implement the Waiver maintains services for Residual consumers to the extent federal funding is available, subject to the terms and conditions of this Waiver. *(This proposed trailer bill language and related policy issues were discussed by the Subcommittee during the May Revision hearing for the Department of Social Services.)*

The May Revision also requests an increase of $734,000 ($367,000 General Fund) to hire 9.5 new staff positions within the Department of Social Services to develop, implement and manage this IHSS Plus Waiver.

Governor's May Revision—DHS State Positions: The May Revision for the DHS requests an increase of $450,000 ($225,000 General Fund) **to support 5 new state staff** (two-year, limited-term) **to develop, implement and provide oversight of this proposed Waiver.**

Subcommittee Staff Comment and Recommendation: It is recommended to approve the May Revision.

Budget Issue: Does the **Subcommittee want to adopt the May Revision.**

17. AIDS Drug Assistance Program (ADAP)—Adjustments to January Budget

Overall Background on the ADAP: ADAP is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have no health care coverage for prescription drugs and are *not* eligible for the Medi-Cal Program. There are about 22,733 clients enrolled in ADAP (as of February 18, 2004).

Under the program eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor. The state provides reimbursement for drug therapies listed on the ADAP formulary (about 151 drugs currently). The formulary includes anti-retrovirals, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible or (2) spend down their assets to qualify for Medi-Cal. About 50 percent of Medi-Cal costs are borne by the state, as compared to only 30 percent of ADAP costs.

Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Antiretroviral Treatment (HAART) which minimally includes three different anti-viral drugs. As such, expenditures in ADAP have increased. Under the program, individuals receive drug therapies through participating local pharmacies under subcontract with a statewide contractor. Studies consistently demonstrate that early intervention, minimizes more serious illness, reduces more costly treatments and maximizes an individuals productivity and health.

The DHS notes that ADAP has grown in response to (1) increased demand brought about, in part, by the development of new, more efficacious but costly therapies, (2) increased caseload, and (3) changes in drug utilization as therapies shift due to drug resistance over the course of treatment as individuals live with AIDS.

Prior Subcommittee Action (March 8th): In the March 8th hearing, the Subcommittee took the following actions: **(1)** rejected the Governor's proposed cap on enrollment into the program, **(2)** enacted program efficiencies to save $800,000 (General Fund), **(3)** adopted trailer bill legislation to establish a special fund for capturing HIV/AIDS drug rebate funds appropriately for usage in the program, and **(4)** provided a net increase of $15 million (rebate funds) for the ADAP.

Governor's May Revision: The May Revision proposes an increase of $26.911 million ($2.760 million General Fund, $3.151 million federal funds, and $21 million Drug Rebate Funds) to the ADAP in order to provide appropriate funding for the program and to meet necessary federal Ryan White Care Act maintenance-of-effort requirements. In addition, the May Revision deletes the Governor's January cap on enrollment proposal.

Subcommittee Staff Comment and Recommendation: The May Revision proposal is a significant improvement compared to the January proposal. **The Governor has conformed to the Legislature's direction regarding not capping enrollment on the program and has recognized that Drug Rebate funds should be appropriated for expenditure when available.** Further, based on additional information, the Administration has recognized the need to provide additional General Fund support in order to meet federal Ryan White CARE Act maintenance-of-effort provisions. In addition, the state was recently notified of the availability of additional federal funds. **As such, it is recommended to rescind the prior Subcommittee action from the March 8th hearing, except for establishment of the trailer bill legislation to establish a special fund for ADAP Drug Rebates, and adopt the Governor's May Revision funding level for the program.**

Budget Issue: Does the **Subcommittee want to (1) adopt the Governor's May Revision** for funding the program, and **(2) retain the trailer bill language** to establish a special fund for Drug Rebates?

18. West Nile Virus—New State Staff and Contract to Develop a Plan

Governor's May Revision: The Governor's May Revision proposes **an increase of $1.0 million (General Fund)** to fund **(1)** two new state positions (one Epidemiology/Bio-statistics positions and one Research Scientist IV--Veterinary), and **(2)** an external contract for $671,000 to develop a strategic plan and program to address the establishment and spread of West Nile Virus.

The DHS states that is has no dedicated funding specifically for West Nile Virus and that funding is not available from the state Department of Food and Agriculture or from other state agencies. Federal funds from the Centers for Disease Control (CDC) have not been provided on the longer-term, only "seed funding" was established for selected states. **As such California, through the Public Health Foundation Enterprises (PHFE), does receive $500,000 in federal funds from the CDC on an annual basis. The PHFE subcontracts with two collaborating laboratories—the Arbovirus Research Unit Laboratory at UC Davis, and the California Animal Health and Food Safety Laboratory.**

Subcommittee Staff Comment and Recommendation: The **prior Administration proposed a similar proposal at the May Revision last year, which was denied due to limited General Fund resources.**

The DHS presently employs **about 200 employees in its Communicable Disease Control Division. This Division consists of several branches as follows: (1)** Disease Investigation and Surveillance Branch, **(2)** Vector Control Section (i.e., mosquito), **(3)** Viral and Rickettsial

Disease Laboratory, **(4)** Microbial Disease Laboratory, **(5)** TB Control, and **(6)** Sexually Transmitted Disease. Further, the DHS also has other branches within it purview—Environmental Health Investigations, Epidemiology and Prevention, and others—that have potential positions **which could be re-directed for this effort.**

Local mosquito and vector control agencies are funded through a variety of mechanisms, such as property taxes, services charges, and benefit assessments. **Though these funds are not available to state agencies, they serve to mitigate mosquitos and thus, West Nile Virus.**

Other approaches than increase General Fund expenditures seem to be available. The DHS could seek addition CDC funds for this purpose (the CDC is providing $500,000 now), the State Department of Food and Agriculture could potential utilizing some of their special funds for this purpose, foundation funds could be used to develop an advertising campaign in lieu of using state General Fund support, and the DHS could re-direct existing resources for this purpose. **As such, it is recommended to deny the May Revision due to limited General Fund resources.**

Budget Issue: Does the Subcommittee want to **(1) deny the proposal**, and **(2) instruct the DHS to redirect existing positions for this purpose?**

19. Medical Marijuana Identification Card—Implementation of SB 420, Statutes of 2003

Background: SB 420 (Vasconcellos), Statutes of 2003, is intended to clarify and implement the provisions of Proposition 215 (Compassionate Use Act of 1996 or the Medical Use of Marijuana Initiative). It requires the DHS to establish and maintain a voluntary medical marijuana identification card and registry program for qualified patients and their primary caregivers through county health departments, or the county's designee. To implement the program, the DHS must establish application and renewal fees to cover DHS' costs of the card registry program. Each county would collect and forward these fees to the DHS and also establish their own fees to cover county health department costs.

Several other states, including Arizona, Alaska, Colorado, Hawaii, Maine, Nevada, Oregon and Washington, have already implemented similar programs.

Major activities associated with DHS implementing SB 420 include the following:

- Development and maintenance of program policies, procedures, protocols, forms and regulations;
- Conducting surveys and meetings with counties and other stakeholders;
- Establishment, review and adjustment of fees which are sufficient to fully reimburse program costs;
- Creation of a special fund, accounting system, and the like to allow counties to transmit fees they collect to the state;
- Providing the 24-hour/7 days a week interactive voice response system;

- Establishment and operation of an appeal process within DHS for patients whose application for a card is denied;
- Identification of county departments or their designees responsible for operating the program at the county level; and
- Pilot testing the program with counties to evaluate the effectiveness of the program and make any identified adjustments.

Governor's May Revision: The May Revision proposes **to establish a loan of $983,000 from the Health Statistics Fund to begin implementation of the Medical Marijuana Identification Card Program.** This loan will provide funds for the first year and one-half of the program, and fees collected from the card program users and their caregivers would be used to repay the loan and continue the operation of the program in subsequent years.

These resources would be used to fund (1) 5 permanent, and 3 two-year limited-term positions, (2) card production, and (3) a 24-hour/ seven days a week interactive voice response system. As referenced above.

Subcommittee Staff Commend and Recommendation: It is recommended to approve the May Revision.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

20. Criminal Background Clearance

Background: State law mandates criminal background screening for all Certified Nurse Assistants (CNAs), Home Health Aides (HHAs), and for specific individuals who are employed in a variety of health facilities licensed and certified by the DHS. While about 90 percent of all applications and renewals are cleared without conviction, the remaining 10 percent for individuals with criminal backgrounds create the complex, increasing workload and backlog within the DHS Licensing and Certification-Fingerprint Investigation Unit.

The DHS receives criminal offender record information from the DOJ on current or potential caregivers. The DHS must review the results of these criminal background checks at three different points through the process as required by statute. **Therefore, in order to expedite these reviews and to ensure their accuracy, automated system changes are necessary to improve the Department of Justices' criminal history information used by the DHS.**

Governor's May Revision: The May Revision **requests an increase of $602,000 ($302,000 General Fund) of which $508,000 (total funds) is a one-time only appropriation**, **with $15,500 as an on-going expenditure.** The purpose of the request is to direct funding to the Department of Justice to make programming changes to their automated systems that support criminal history information used by the DHS Licensing and Certification Program.

Subcommittee Staff Commend and Recommendation: It is recommended to approve the May Revision.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

21. Child Health Disability Prevention (CHDP) Program

Background: Overall Background: The Child Health Disability Prevention (CHDP) Program **provides pediatric prevention health care services to (1)** infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and **(2)** children and adolescents who are eligible for Medi-Cal services up to age 21 (Early Periodic Screening Diagnosis and Treatment—EPSDT).

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health examination certificate or an equivalent examination to enroll in school.

The benefit package provided under the *CHDP-only* program is limited to providing a physical examination, nutritional assessment, vision and dental assessments, hearing assessment, laboratory tests and immunizations. Local health jurisdictions work directly with CHDP providers (private and public) to conduct planning, education and outreach activities, as well as to monitor client referrals and ensure treatment follow-up. With respect to funding, services for

Governor's May Revision: The **May Revision proposes total expenditures of $5.7 million** ($5.4 million General Fund and $300,000 Childhood Lead Poisoning Prevention Funds) for the program. **No policy changes are proposed.** The May Revision does reflect a 5 percent rate reduction which is consistent with the Budget Act of 2003.

Subcommittee Staff Recommendation: It is recommended to adopt the May Revision.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

22. Clarifying State Law for County Organized Health Systems (COHS) & Local Initiatives for Purposes of Intergovernmental Transfer

Background--Potential Option to Use Intergovernmental Transfer Funds: Voluntary intergovernmental transfer mechanisms are currently being used by California to draw down additional federal matching funds for use in the Medi-Cal Program without expenditure of state General Fund support. Specifically this is done under the state's SB 1255 Supplemental Payment Program accessed by certain hospitals. This intergovernmental transfer mechanism is limited by the amount of savings the state is able to achieve through its Selective Provider Contracting Program (whereby the CMAC contracts with certain hospitals for Medi-Cal inpatient days). The federal funds saved by hospital contracting are then allocated back to hospitals for supplemental funding. Due to federal "upper payment limits" ("OBRA" limits), some hospitals are limited on the amount of federal supplemental funding that they can receive.

The Administration has been having discussions with interested parties on the concept of using a similar intergovernmental transfer mechanism for COHS and the Local Initiatives. Key aspects of this discussion have been as follows:

- What would the source of the funds for the intergovernmental transfer be?
- Would federal approval be provided for such a mechanism for COHS?
- Would there be any upper payment issues that hospitals or the state would encounter?

Prior Subcommittee Hearing (April 12th): In this Subcommittee hearing, discussions pertaining to the fiscal viability of County Organized Health Systems were discussed. The DHS noted that there may be other mechanisms available to assist with their fiscal viability, as well as the Local Initiatives as part of the Two-Plan Model for Medi-Cal Managed Care.

Subcommittee Staff Recommendation: As noted in the April 12th hearing, discussions with the Administration have been occurring to see if the state can better articulate to the federal CMS that COHS and Local Initiatives are indeed public authorities that could participate in the intergovernmental transfer process, and therefore, obtain additional federal funds. **As such, it is recommended to adopt placeholder trailer bill language to be worked out with the Administration on** this topic. Further, it is the understanding of Subcommittee staff that the Administration is interested in this topic conceptually and would be interested in pursuing the conversation through Conference Committee.

Budget Issue: Does the **Subcommittee want to adopt placeholder trailer bill language** which further articulates that COHS' and Local Initiatives are public entities and can participate in the intergovernmental transfer process?

23. Non-Contracting Hospital Field Audits & Home Office Audits (BCP and May Revise

Background—Hospital Cost Reports: There are about **440 licensed hospitals in California**. Medi-Cal pays about $3.5 billion (total funds) for **inpatient hospital services** annually of which **20 percent or $700 million (total funds) is paid to "non-contract" hospitals.** ***Non-contract*** **hospitals** are those who provide inpatient services to Medi-Cal patients but do not operate under a contract with the California Medical Assistance Commission (CMAC).

All **Acute care hospitals who provide care to Medi-Cal patients are required to file an annual cost report with the DHS.** There are currently 428 cost reports submitted annually for this purpose. **Of the 428 cost reports about 210 are cost reports for non-contract hospitals.** The remaining 218 cost reports are for hospitals that are under contract with the CMAC.

The DHS states that they review 100 percent of the cost reports for all hospitals. However, the DHS contends that they do not have enough staff to do "full scope" field audits. The DHS states that during the performance of full field audits, procedures are performed to test the validity and accuracy of the hospital's allowable costs and billings more extensively than during a limited desk review or limited field review. Audit tests are performed to ensure that hospital records support not only the cost report but also the claims submitted to Electronic Data Systems for processing.

Background—Home Office Information: According to the DHS, there are 62 large corporate healthcare chains (Home Offices) that own many of California's hospitals**.** These home offices are also required to file annual cost reports with the DHS. These cost reports show the total costs

of the home offices and how they allocate costs—such as central management and administrative services-- to the individual hospitals they own in California.

The home office costs are not reimbursed to the home office directly but are included by cost accounting and allocation methods in the individual hospital reports. According to the DHS, these methods of accounting and allocation can be manipulated to increase Medi-Cal reimbursement to the individual hospital.

The DHS states that with current resources, they perform primarily limited field/desk audits of the non-contract hospitals and limited field audits of only 13 of the 62 home offices (remaining 49 are accepted as filed without audit).

Governor's January Budget and May Revision: The budget is requesting **an increase of 41 new audit staff for increased costs of $4.7 million ($2.4 million General Fund), including $531,000 (total funds) for out-of-state travel. The DHS contends that with this additional audit staff they will be able to save $12.4 million ($6.2 million General Fund) in 2004-05, or a *net* savings of $3.8 million General Fund in the budget year.**

The DHS contends that 41 new positions are required to perform the additional audit workload to audit all 62 home offices (currently doing 13) and 210 non-contract acute care hospitals. Since 20 of the 62 home offices are located outside of California, out-of-state travel is being requested. The DHS states that typically it takes three to four consecutive two-week trips (6 weeks to two months of time) involving three to four audit staff to conduct a home office audit.

Legislative Analyst Office Recommendation: In her Analysis, the LAO notes that the DHS **received 161.5 additional new positions** for anti-fraud activities in 2003-04**. Of these new positions, the Administration chose to eliminate some as part of the Control Section 4.1 process (as contained in the Budget Act of 2003). In addition, some of these remaining positions are still being recruited for and are as yet not all filled.**

As such, the LAO believes that it is premature to approve further expansion before the DHS has implemented the sizable expansion approved last year and demonstrate that it can achieve the savings that were to have resulted from these additional positions.

Further, the LAO contends that expansion in this area should also wait until the Error Rate Study is completed that will shed light on which types of anti-fraud activities warrant a greater focus. As noted above under the background discussion, this Error Rate Study will not be completed until November 2004.

Subcommittee Staff Comment and Recommendation: Subcommittee staff also has concerns similar to those articulated by the LAO in that, the DHS typically has difficulties hiring staff, training staff and bringing them on board to achieve the level of cost containment savings that are assumed in their budget proposals. **Further discussions regarding necessary staff needs and a hiring plan need to be further discussed. As such, it is recommended to send this proposal to Budget Conference Committee.**

Budget Issue: Does the Subcommittee **want to (1) provide a total of 20 new audit staff, and (2) assume the same level of local assistance savings as the May Revision (i.e., $12.4 million**

total funds)? (This will send the issue to the Budget Conference Committee for further discussions regarding the necessary staffing levels.)

24. Prostate Cancer—Budget Year Discussion

Background: The Prostate Cancer Treatment Program provides prostate cancer treatment to low-income men who are uninsured. To enroll in the program, a man must be a California resident, have an income at or below 200 percent of poverty, be uninsured and not eligible for Medi-Cal or Medicare. The program is not an entitlement and must operate within its level of appropriation.

Clarification of Prior Years Funding: The Budget Act of 2001 appropriated $20 million (Tobacco Settlement Funds) for the program. Based on expenditures of $8.7 million, a remaining balance of $11.3 million was available for re-appropriation. Due to a mid-year reduction adjustment, the final, revised budget for 2002-03 provided an appropriation of $10 million. Total expenditures were $8.6 million which left $1.4 million available for re-appropriation for 2003-04.

Budget Act of 2003 and Subsequent Revisions: The Budget Act of 2003 appropriated $5 million (General Fund) for the program. **The appropriation was made in Provision 9 of Item 4260-001-0001 and allows for encumbrance of these funds through June 30, 2005 and expenditure through December 31, 2006.**

However as recently noted by the DOF, the Governor's revised 2004 budget as updated in January 2004, contains a technical error regarding the level of funds actually available for re-appropriation from 2002-03 for expenditure. **In total, a re-appropriation amount of $12.7 million is available for 2003-04.**

The Administration, using Budget Control Section 4.1, reduced the program by about $4.5 million (General Fund). ***(This action is discussed further below.)***

In addition, the Budget Act of 2003 also included a transfer of $6 million of overall Tobacco Settlement Funds to the General Fund. The Prostate Cancer Program was reduced by $1.7 million as part of this transfer.
The following chart summarizes the above outlined items which affect 2003-04 :

Budget Act of 2003 Appropriation	$5 million
Governor Schwarzenegger's Control Section 4.1 Reduction	($4.5 million)
Governor's Proposed Revised 2003-04 Appropriation	**$545,000**
Revised Re-Appropriation from Prior Years	$12.7 million
Transfer for Tobacco Settlement Fund	($1.7 million)
Governor's Proposed Total Revised Funding	**$11.5 million**
Anticipated Expenditures	$5 million
Amount Likely Available for Re-appropriation for 2004-05	**$6.5 million**

The DHS notes that the $5 million in anticipated expenditures is based on actual expenditures through December 31, 2003. The DHS has a contract with UCLA for $4.6 million to provide clinical services, administration, case management, outreach and evaluation. The DHS utilizes the remaining amount for their administration.

It should be noted that 188 men are currently under-going treatment in the program and 103 men are considered new enrollees for a total of 291 men being served in 2003-04.

Legislative Counsel Opinion and Budget Control Section 4.1 of the Budget Act of 2003: At the request of Senator Ortiz, Legislative Counsel conducted an analysis of Budget Control Section 4.1 (Control Section) and the application of it by the DOF specifically to the Prostate Cancer Program. **Through this analysis, Legislative Counsel notes the following key factual aspects:**

- The Control Section **limits the reductions** to a state operation appropriation, and a program, project or function designated in any line of any schedule set forth by that appropriation, **may not be reduced by this section by more than 15 percent** (See **Subdivision h of the Control Section**).
- Item 4260-001-0001 (DHS state support item) was reduced by about $15.5 million from an appropriation of $264.1 million. This equates to less than 15 percent overall. **However, the DOF specifically reduced the Prostate Cancer Program by about 89 percent (i.e., a reduction of $4.5 million from an appropriation of $5 million).**
- Budget Act Language**-- Provision 9 of Item 4260-001-0001--directs that $5 million of the amount appropriated in this Item shall be appropriated for the Prostate Cancer Program. As such, the Legislature authorized a definite sum of money for a specific purpose—the Prostate Cancer Program.**

In an extensive analysis, **Legislative Counsel concludes that, in their opinion, the Control Section does not authorize the Director of Finance to eliminate or reduce an appropriation made in the Budget Act for a program in an amount that exceeds 15 percent if the program is a designated program for which an appropriation has been made (such as the Prostate Cancer Program).**

They state that the DOF's construction of the Control Section in this case is clearly erroneous because applying a 15 percent reduction to a schedule (meaning the entire Item 4260-001-0001) could result in the total elimination of an appropriation for a program for which the Legislature has made a specific designation, which is clearly not intended as noted in Subdivision h of the Control Section.

Governor's Proposed 2004-05 Budget: The budget proposes **(1)** an appropriation of $570,000 (General Fund), and **(2)** re-appropriation language to capture the estimated $6.5 million available from prior years (as referenced above). **Specifically the re-appropriation language is as follows:**

4260-491 (Tobacco Settlement Fund)

(1) Item 4260-001-3020, **Budget Act of 2001**. Notwithstanding any other provision of law, the balance as of June 30, 2004 for the Prostate Cancer

Treatment Program is re-appropriated and is available for expenditure through June 30, 2005.
(2) Item 4260-001-3020, **Budget Act of 2002**. Notwithstanding any other provision of law, the balance as of June 30, 2004 for the Prostate Cancer Treatment Program is re-appropriated and is available for expenditure through June 30, 2005.

Prior Subcommittee Hearing (May 3rd): The Subcommittee heard public testimony regarding the program and the need for the re-appropriation language. The issue was kept open, pending receipt of the May Revision.

Governor's May Revision: The Governor's May Revision reiterates that the re-appropriation will enable the program to continue to expend $6.5 million (Tobacco Settlement Funds) for 2004-05

Budget Issue: Does the **Subcommittee want to adopt** the Governor's budget as proposed?

25. Cancer Research Program Funding—Budget Year

Background and Clarification of Prior Years Funding: Chapters 755 and 756, Statutes of 1997 (AB 1554, Ortiz and SB 273 Burton), created the Cancer Research Act of 1997. From 1998 to 2001, the annual Budget Act provided $25 million (General Fund) for this program.

Due to fiscal constraints, the Budget Act of 2002 and accompanying legislation (1) reduced the appropriation level to $12.5 million, **(2)** allowed for the receipt of private donations to the program, **(3)** capped the indirect costs for the grants at 25 percent, ***and*** **(4)** provided for multiple-year contracting for the grants. **However, a Mid-Year Reduction (Control Section 3.90) adjusted this appropriation to $6.25 million (General Fund) for 2002-03.**

The Omnibus Health Trailer Bill (Chapter 1161, Statutes of 2002) provided for unencumbered and unexpended balances from prior fiscal years (1999-2000, 2000-01 and 2001-02) for the Cancer Research Program to be re-appropriated and to be available for encumbrance and expenditure until July 30, 2005 (this date was chosen due to the multiple year nature of research grants). **This re-appropriation provided an additional $2.6 million. Therefore, total resources available for expenditure for 2002-03 was $8.8 million (including the appropriation and re-appropriation). Actual expenditures were $6.1 million (as of June 2003). Therefore, about $2.7 million was remaining as a balance for re-appropriation.**

The Budget Act of 2003 appropriated $3.125 million (General Fund) for the program. The appropriation was made in Provision 14 of Item 4260-001-0001. The Administration, using Budget Control Section 4.1, eliminated the entire General Fund appropriation. ***(This action is discussed further below.)***

The Budget Act of 2003 also included re-appropriation language that allows for the expenditure of unspent Cancer Research Funds appropriated in the Budget Act of 2002. As such the $2.7 million was the amount that was unspent; however, the DHS states that $1.9 million is the anticipated expenditure and encumbrances as of May 5, 2004. **Therefore, about $800,000 is likely to be available for re-appropriation.**

Legislative Counsel Opinion and Budget Control Section 4.1 of the Budget Act of 2003: At the request of Senator Ortiz, Legislative Counsel conducted an analysis of Budget Control Section 4.1 (Control Section) and the application of it by the DOF specifically to the Prostate Cancer Program. **Through this analysis, Legislative Counsel notes the following key factual aspects:**

- The Control Section **limits the reductions** to a state operation appropriation, and a program, project or function designated in any line of any schedule set forth by that appropriation, **may not be reduced by this section by more than 15 percent** (See **Subdivision h of the Control Section**).
- Item 4260-001-0001 (DHS state support item) was reduced by about $15.5 million from an appropriation of $264.1 million. This equates to less than 15 percent overall. **However, the DOF specifically eliminated funding for the Cancer Research Program.**
- Budget Act Language**-- Provision 14 of Item 4260-001-0001--directs that $3.125 million of the amount appropriated in this Item shall be appropriated for the Cancer Research Program. As such, the Legislature authorized a definite sum of money for a specific purpose—the Cancer Research Program.**

In an extensive analysis, **Legislative Counsel concludes that, in their opinion, the Control Section does not authorize the Director of Finance to eliminate or reduce an appropriation made in the Budget Act for a program in an amount that exceeds 15 percent if the program is a designated program for which an appropriation has been made (such as the Prostate Cancer Program).**

They state that the DOF's construction of the Control Section in this case is clearly erroneous because applying a 15 percent reduction to a schedule (meaning the entire Item 4260-001-0001) could result in the total elimination of an appropriation for a program for which the Legislature has made a specific designation, which is clearly not intended as noted in Subdivision h of the Control Section.

Governor's Proposed Budget: The Governor's budget proposes no appropriation for the Cancer Research Program. However, re-appropriation language (in Item 4240491-0589) is included which allows for expenditures of any unspent Cancer Research Funds appropriated in the Budget Act of 2002 (less than $800,000).

Budget Issue: Does the Subcommittee want to adopt the Governor's budget for 2004-05?

26. Legislative and Governmental Affairs—Send to Conference

Background: Within the Department of Health Services, the Legislative and Governmental Affairs Office provides analyses regarding legislation, assists in the crafting of trailer bill language, responds to legislative inquiries regarding the department's programs and activities, and generally serves an important liaison function between the department and the Legislature, as well as with the Administration.

Subcommittee Staff Comment and Recommendation: The Legislative and Governmental Affairs Office serves a critical role in providing assistance for the development of legislation and subsequently, state law. However, concerns have arisen with respect to some operations of the office and discussions have been instituted to remedy the communication and to facilitate a constructive outcome. But this has not come to full fruition. Therefore, it is recommended to delete one Legislative Coordinator position and all related dollars (about $80,000) to send the issue to Conference Committee so that discussions can continue.

Budget Issue: Does the **Subcommittee want to delete one Legislative Coordinator position and related funding?**

F. Item 0530 — CA Health & Human Services Agency *(Vote Only)*

1. California Health and Human Services (CHHS) Agency—Request for Staff

Background: The Administration is committed to having the CHHS Agency play a strong and active role in the health and human services arena that is policy focused and outcome oriented. Specifically, CHHS Agency's role will be one of policy leadership and oversight, and its focus will be toward reducing duplication and fragmentation among CHHS departments in policy development and implementation, improving coordination among departments on common programs, ensuring programmatic integrity, and advancing the Governor's priorities in health and human services. The CHHS Agency oversees 12 departments and one board.

Budget Act of 2003: During budget deliberations for the Budget Act of 2003, the CHHS Agency **was reduced by $807,000 (General Fund) due to the fiscal condition of the state.** As such, the appropriation for the CHHS Agency in the current year (2003-04) is $1.9 million, excluding the Office of HIPAA Implementation. In effect, the Legislature determined that only core activities should be supported by state operations in order to prioritize available state funding for the direct provision of health services for clients.

Governor's Finance Letter Request: The Administration is requesting **an increase of $1.372 million (General Fund), or an increase of *over 70 percent*, to (1)** fund existing 13 positions **unfunded positions for increased expenditures of $1.163 million, and (2) fund 4 newly requested positions to support the work of the CHHS Agency for increased expenditures of $209,000 (General Fund).**

The total amount for the CHHS Agency would be almost $3.3 million (General Fund), excluding the Office of HIPAA, if this request were approved.

In addition, in the March 8th hearing, **the Subcommittee provide funds of $364,000 for two positions and contract funding to establish the new California Health Care Quality Improvement and Cost Containment Commission.**

The existing unfunded positions are the following:

- 1 Undersecretary (exempt)
- 1 Agency Information Officer
- 2 Assistant Secretaries—Program and Fiscal
- 3 Associate Governmental Program Analysts
- 2 Office Technicians
- 1 Chief Legal Counsel
- 1 Assistance Secretary-Ethnic Media
- 1 Special Assistance to the Secretary
- 1 Executive Assistant

It should be noted that all of the above non-exempt, unfunded positions will have been vacant for six months as of July 1, 2004; therefore, the CHHS Agency is also requesting that these positions be administratively re-established.

The requested new positions are the following:

- 1 Associate Governmental Program Analyst
- 1 Executive Assistant
- 1 Office Technician
- 1 Office Technician

Legislative Analyst's Office (LAO) Recommendation: Based on the LAO's analysis of information provided by the Administration, **the LAO recommends the following modifications to the proposed Finance Letter (reduces by $970,000 General Fund, and provides an *additional* $400,000 General Fund above the current-level):**

- **Delete one of the four new proposed** agency positions **and the associated $57,000 (General Fund);**
- **Delete funding and position authority for five of the 13 vacant positions for which the administration proposes to restore funding. This would reduce the Administration's request by an additional $585,000 (General Fund);**
- **Eliminate six positions and $329,000 in state General Fund support (as well as some additional associated federal funding) for six positions which had been borrowed in the past from other state departments, but who would be replaced at agency as a result of the Governor's budget request.**
- **Adopt Budget Bill Language** requiring advance legislative notification and review of any additional borrowing of staff by the agency from other departments during the 2004-05 fiscal year.

The LAO states that a total of 11 positions would be provided --three new positions (of the four positions requested) and eight additional positions for which the Agency already has position authority.

Also, six other "borrowed" positions in other departments would be abolished. The LAO contends that the Agency's budget request did not justify the return of certain departmental positions and resources to lending departments. However, in general, the LAO concluded that the Administration's proposal to reduce its borrowing of staff for agency functions from other departments has merit and would contribute to a "truth-in-budgeting" approach.

In essence, the LAO's recommendation restores about 50 percent of the amount reduced in the Budget Act of 2003, and provides additional positions.

The LAO's proposed Budget Bill Language is as follows:

> Provision x.
>
> "The Secretary of the California Health and Human Services Agency shall not approve the borrowing of any additional positions from any state department for the support of agency activities unless the approval is made in writing and notification has been provided in writing not later than 30 days prior to the effective date of the approval to the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the fiscal committees of both houses of the Legislature."

Budget Issue: Does the **Subcommittee want to adopt the LAO recommendation?**

II. ITEMS FOR DISCUSSION *(Shown by Department)*

A. Item 4280--Managed Risk Medical Insurance Board (*Discussion Items*)

The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health coverage through private health plans to certain groups without health insurance. **The MRMIB administers the (1) Healthy Families Program, (2) Major Risk Medical Insurance Program, and (3) Access for Infants and Mothers (AIM) Program.**

1. Healthy Families Program Estimate—*Baseline Children's Estimate*

Background—Overall on the HFP: The Healthy Families Program provides health, dental and vision coverage through managed care arrangements to uninsured children in families with incomes **up to 250 percent of the federal poverty level. In addition, in accordance with the Budget Act of 2003, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program who** enter the program on or after July 1, 2004, will be enrolled in the HFP at birth.

Families pay a monthly premium and co-payments as applicable. Families typically pay between $4 to $9 per child each month (with a monthly maximum of $27 per family) for the HFP. The amount paid varies according to a family's income and the health plan selected.

The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis. California receives an annual federal allotment of Title XXI funds (federal State-Children's Health Insurance Program) for the program for which the state must provide a 35 percent General Fund match.

Governor's January Budget: The Governor's January budget **proposed significant changes to the Healthy Families Program, including implementation of an enrollment cap and county block grant, and development of a two-tiered benefit structure.**

Prior Subcommittee Action (March 8th Hearing)—Rejected Caps and Other Items: The **Subcommittee rejected** the Administration's proposals **to cap enrollment, create a county block grant and to develop a two-tiered benefit structure. Increased General Fund support was provided to backfill for these items. In addition, the Subcommittee deleted $500,000 ($175,000 General Fund) for a consumer survey.**

Governor's Proposed May Revision: In his **May Revision, the Governor rescinds his January proposal to implement an enrollment cap and county block grant, and to develop a two-tiered benefit structure. In addition, caseload and other technical adjustments to the baseline are proposed.**

The May Revision proposes total expenditures of $872 million ($319.1 million General Fund, $544.1 million federal funds, $1 million in Proposition 99 Funds—Unallocated, and $7.8 million in Reimbursements**)**. **This level of funding assumes a total enrollment of 774,077 children** as of June 30, 2005.

The May Revision reflects an increase of $32.9 million ($13.6 million General Fund) over the Governor's January budget. The key factors included in this adjustment are as follows:

- **Caseload increase of 59,631 children** as compared to January. **This is primarily due to the elimination of the enrollment cap proposal,** as well as other adjustments related to enrollment from the Child Health Disability Prevention (CHDP) Gateway.
- **$91.46 (average cost) for health, dental, and vision plan payments per child per month** (eligible children aged 1 to 19 years). This assumption is the same as in the current year.
- With respect to infants born to Access for Infants and Mothers (AIM) who enrolled on or after July 1, 2004, the May Revision assumes a negotiated "lump sum" rate which covers the infant for the first two-months of enrollment after which the current (existing rate) for the Healthy Families Program infant rate will be used for the remaining ten months (total of one-year). It is assumed that 67 percent of these AIM infants will be under 250 percent of poverty (and therefore eligible for a 65 percent federal match). **Further, it should be noted that MRMIB anticipates federal approval of a State Plan Amendment to draw down a federal match (65 percent under Title XXI S-CHIP) for those infants in families with incomes between 251 percent to 300 percent federal poverty level.**
- The average premium payment per child per month is assumed to be $5.50, which is the same as the current-year.
- Continues the Rural Health Demonstration Projects at $2.887 million ($1.047 million Proposition 99 Funds and $1.840 million federal funds) at the same level as proposed in January.
- Provides an increase of $240,000 ($84,000 General Fund) to fulfill a contractual agreement with the HFP Administrative Vendor (MAXIMUS) to obtain the services of a state-approved independent audit firm to perform periodic compliance audits and internal control evaluations.

Subcommittee Request and Questions: The Subcommittee has requested the MRMIB to respond to the following question:

- Please **very briefly** summarize the key changes of the Governor's May Revision.

Budget Issue: Does the **Subcommittee want to (1) adopt the baseline adjustments as outlined above which now conform to the Subcommittee's prior action to reject the January enrollment caps, delete the county block grant and reject the proposed to develop a two-tiered program, and (2) retain the Subcommittee's action to delete funds for the consumer survey ($175,000 General Fund)?**

2. Governor's Proposed Change to Healthy Family Program Premiums *(See Hand Out)*

Background—Summary of Existing Premium Structure: Families pay a monthly premium and co-payments as applicable. Families typically pay between $4 to $9 per child each month (with a monthly maximum of $27 per family) for the HFP. The amount paid varies according to a family's income and the health plan selected.

There are no health plan co-payments for preventive services and a $5 co-payment for non-preventative services. The HFP has an annual cap of $250 per family for co-payments.

Governor's Proposed May Revision—Increase Premiums as of July 1, 2005: In his May Revision, the **Governor proposes to increase HFP premiums beginning July 1, 2005 in lieu of proceeding with a two-tiered benefit proposal.** The Subcommittee rejected the Governor's January proposal regarding the two-tiered benefit concept in its March 8th hearing.

No budget year savings are proposed since implementation would occur in 2005-06. However, the Administration states that this policy change would result in savings of about $5.4 million (General Fund) in 2005-06, with a small amount of increased savings in future years due to caseload growth.

In the May Revision, the Administration is seeking trailer bill language (See Hand Out) to change the premium and an increase of $750,00 ($263,000 General Fund) to make system changes. These items are discussed further below.

Specifically under this proposal, **all HFP children with family incomes between 201 percent and 250 percent of the federal poverty level would have their premiums increased. The monthly premiums would be increased from $9 per child to $15 per child and from $27 for three or more children to $45 for three or more children.** According to the Administration's figures, **an estimated 225,000 children would pay higher premiums** under this proposal in 2005-06, assuming a July 1, 2005 implementation date.

The Administration states that even with this proposed premium increase, families' total out-of-pocket costs (premiums and co-payments) would not exceed the five percent maximum allowed under federal regulations. The Administration states that the increased premium would represent 2.3 percent of the federal maximum. They determined this percentage as follows:

- 200 percent of federal poverty for a **family of four** = $3,068 per month or $36,816 annually
- **5 Percent** of the annual income = $1,841
- Administration's Proposed Premiums and Co-Payments (Effective July 1, 2005) Calculation:
    - Proposed annual premium of $15 per child = $360 annually
    - Annual Family Cap on Health Co-Payments = $250 annually
    - Dental and Vision Co-Payments (12 months @$5 per child) = $240 annually
        - **Total Proposed Premiums and Co-Payments = $850 annually**
        - Percent of Family's Annual Income = 2.3 percent

The Administration notes that 12 other states have increased their program's premium payments. However, 8 of these states do not have any co-payment requirement—families only pay a premium. Whereas California has premiums and co-pays (for health, dental and vision) as noted above.

Governor's May Revision Request for System Changes: **For purposes of the budget year, the Administration is seeking an increase of $750,000 ($263,000 General Fund) to conduct system changes to prepare for the premium increase.** The Administration states that several activities would need to occur in order to implement the premium change. These include the following:

- Administrative Vendor would need to "re-program" the system logic that calculates the HFP premium and the posting logic for HFP accounts and monthly billing statements. These changes would need to begin at least three months in advance of the program change.
- Notices would need to be mailed out to families. The MRMIB states that these notices would have to be mailed out in March 2005.

Subcommittee Staff Comment and Recommendation: Based on the proposed implementation schedule to conduct system changes, there is considerable time available for the Administration to proceed with policy legislation on this topic. **First,** the proposal has provided no rational as to why $15 (from $9) per child per month, and $45 (from $27) for three or more children were selected. The jump to $15 and $47 respectively represents a 66 percent increase over the existing premiums. Further analysis is warranted for such a substantial change. **Second**, any cost sharing changes proposed for the HFP should be discussed in the broader framework of the cost to live and subside in California based on family incomes of 200 to 250 percent of poverty. Third, the requested appropriation for system changes is putting the chart before the horse. The policy implications for such a proposal need to be analyzed prior to funding any system changes. An appropriation could be included in the enabling legislation.

Subcommittee Request and Questions: The Subcommittee has requested for the MRMIB to respond to the following questions:

- **1. Please provide a brief summary of the May Revision proposal.**
- **2. Why were the premium payments of $15 and $45 respectively selected? What is the basis for the figures exactly?**
- **3. Why can't a policy bill be crafted on this issue so fuller deliberations can take place?**

Budget Issue: Does the **Subcommittee want to reject the request** to increase by $750,000 ($263,000 General Fund) for system changes to implement a monthly premium increase for HFP children commencing as of July 1, 2005?

3. Access for Infants and Mothers (AIM) Program—*Several Adjustments*

Background—What is AIM?: The **Access for Infants and Mothers (AIM) Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Eligible women select coverage from one of the nine participating health plans. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage.**

Beginning July 1, 2004, infants in families between 200 and 250 percent of poverty are funded through the Healthy Families Program using General Fund and federal Title XXI funds (35 percent/65 percent). AIM infants in families between 250 and 300 percent of poverty (above the Healthy Families Program income threshold) are funded with 100 percent state funds (General Fund and Proposition 99 Funds). This fiscal arrangement enables the state to more effectively utilize available federal funds and state funds.

Governor's May Revision: The May Revision proposes **total expenditures of $118.6 million** ($100.2 million Perinatal Insurance Fund—receives Proposition 99 Funds--, $6.4 million General Fund, and $11.9 million federal funds). **This reflects a *net* increase of $445,000 (increase of $676,000 Perinatal Insurance Fund, and a decrease of $81,000 General Fund and $150,000 in federal funds) from January and is based on several key adjustments—*rate increases and caseload reductions*.**

First, it reflects an adjustment to caseload. This level of funding assumes an average monthly enrollment of 12,540 women and infants, compared to 14,140 women and children as originally proposed in the Governor's January budget. As such, a reduction of about 1,600 women and children is expected.

Second, the average, one-time capitation fee was increased from $7,665 to 8,275 based on negotiated rates approved by the MRMIB on April 28, 2004. **This rate is about $609, or almost 8 percent higher than the current year.**

Third, the rates for infants born to Moms enrolled on or after July 1, 2003 has been revised to about $545 based on negotiated rates also approved by the MRMIB Board. **This rate is about $41 higher than the current year. In addition, the average fee for infants from one to two years increased to $128, or an increase of about $10.78.**

Subcommittee Request and Questions: The Subcommittee has requested the MRMIB to respond to the following questions:

- 1. Please provide a brief summary of the May Revision, including the rate increases.

Budget Issue: Does the **Subcommittee want to adopt the May Revision?**

4. Access for Infants and Mothers (AIM) Program Reserve—LAO Recommendation

Legislative Analyst Office Recommendation—AIM Reserve Funds Available: In her Analysis, the **Legislative Analyst recommends for the Legislature to repeal the statutory requirement that the AIM Program maintain a reserve in the Perinatal Insurance Fund, thereby achieving about $1 million in Proposition 99 Funds. (These funds can be used to backfill for General Fund support in certain program areas.)**

The LAO's analysis indicates that there is no need for a separate and special reserve fund for AIM. **In the event that AIM Program expenditures exceed the 2004-05 budgeted amount, an alternative source of funding is available to fund unanticipated expenses. Specifically, a separate reserve is maintained for state programs supported through Proposition 99. The Governor's budget also sets aside some reserves for uncertainties.**

Prior Subcommittee Hearing Action (March 8th): The **Subcommittee adopted the LAO recommendation** to repeal the statutory requirement that the AIM Program maintain an additional reserve. **However at the time of the hearing, the $1 million in Proposition 99 Funds that is attributable to this reserve was not allocated, pending the receipt of the May Revision.**

Subcommittee Staff Comment and Recommendation: Since the Governor's May Revision directs unspent Proposition 99 Funds from AIM (dollars not needed in the program due to decreases) to backfill a portion of General Fund support in the State Hospital item, it is recommended to do the same with this reserve (almost $1 million)**. As such, it is recommended to appropriate the additional $1 million to the State Hospital item.**

Subcommittee Request and Questions: The Subcommittee has requested the LAO to respond to the following questions:

- **1.** LAO, is this reserve amount still available?
- **2.** LAO, is it viable to use this reserve amount to backfill for additional General **Fund support in the State Hospitals?**

Budget Issue: Does the Subcommittee want to adopt using the $1 million (Proposition 99 Funds) to backfill for General Fund support in the State Hospital item?

B. Item 4440 Department of Mental Health (*Discussion Items*)

COMMUNITY BASED ISSUES

Overall Background—County Mental Health Plans: **Though the department sets overall policy for the delivery of mental health services, County Realignment revenues are currently the largest revenue source for community mental health services in California. The second largest revenue source is federal Medicaid (Medi-Cal) dollars. Most of the state's General Fund support is expended on state-operated State Hospitals in order to serve Penal Code related patients.**

Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs as prescribed by State-Local Realignment statutes enacted in 1991 and 1992.

Specifically, County Mental Health Plans are responsible for the provision of services for the following:

(1) All mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available;

(2) The Medi-Cal Mental Health Managed Care Program;

(3) The Early Periodic Screening Diagnosis and Testing (EPSDT) Program for adolescents (state entitlement program provided by the counties via a state Settlement Agreement);

(4) Mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families.

Concerns with Lack of Growth Funds: As discussed in a recently released report on mental health realignment (AB 328 Realignment Data, Department of Mental Health, February 5, 2003), **due to continued caseload growth in Child Welfare services and Foster Care, as well as cost increases in the In Home Supportive Services (IHSS) Program, growth distributions to the Mental Health Subaccount and Health Subaccount have been substantially reduced. This is because the first claim on the Sales Tax Growth Account goes to caseload-driven social services programs, not the Mental Health Subaccount.**

1. Mental Health Managed Care Program—No Medical Adjustment Again

Overview of Mental Health Managed Care: Implementation of Medi-Cal Mental Health Managed Care has included the consolidation of Medi-Cal psychiatric inpatient hospital services ("Phase I"), which occurred in January 1995 and the consolidation of Medi-Cal specialty mental health services ("Phase II"), which occurred from November 1997 through June 1998.

These two phases of implementation consolidated the two existing Medi-Cal mental health programs (Short-Doyle and Fee-For-Service) into one service delivery system. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government (i.e., HCFA, now the Centers on Medicare and Medicaid—CMS).

Under this delivery system, psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists, and some nursing services**, became the responsibility of a single entity, the Mental Health Plan (MHP) in each county. Medi-Cal recipients *must* obtain services through the MHP.**

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the MHPs to ensure quality of care and to comply with federal and state requirements.

Under this model, **MHPs generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. An annual state General Fund allocation is also provided to the MHP's.**

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

State General Fund Allocation: **The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI)for medical services, and other relevant cost items.**

***However*, the state's allocation is contingent upon appropriation through the annual Budget Act. As such in more difficult fiscal years, state General Fund support has *not* been provided for the medical CPI, or the base level of funding has been proposed for reduction (such as this year).**

Background and Budget Act of 2003: Under the consolidated system, as referenced above, County MHPs accept a fixed amount of non-federal funds, based on the amount of resources the state was spending in 1994-95, which is suppose to be adjusted annually to reflect changes in the medical CPI and adjustments in caseload. **However, County MHPs have received no medical CPI adjustment since the Budget Act of 2000, and the Governor's proposed budget does not include this adjustment either.**

Further, in the Budget Act of 2003, a five percent reduction to General Fund support ($11 million) in the program was enacted due to the fiscal crisis. Since this was a reduction to the base funding, it is an ongoing reduction to County MHPs.

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

Governor's May Revision—No COLA Yet Again: The May Revision proposes a total state General Fund appropriation of $222.4 million (General Fund) for allocation to the County MHPs to assist in funding the Waiver Program. This reflects a net decrease of $480,000 (General Fund) in the amount the state provides to the counties for Mental Health Managed Care. Most of this net decrease is due to an adjustment of caseload. **It should also be noted that no medical CPI adjustment is provided. This equates to a loss of $15.8 million ($7.9 million) for the County MHPs for 2004-05. (These funds are used to draw down the federal match too.)**

Subcommittee Staff Comment and Concern: The **County MHPs are shouldering a continuing larger fiscal burden for the state's Mental Health Managed Care Program.** Cumulatively, the state has either not provided medical CPI adjustments, as once agreed to, or has made rate reductions. **As noted in the summary below, the state has saved at least $28.3 million (General Fund) from 2001-02 to 2003-04 by not providing the County MHPs General Fund support as originally contemplated in the agreement with the counties. This figure does not take into account any compounding fiscal effect that would have occurred over the years from these actions.**

In addition, the proposed May Revision adds an additional reduction of $15.8 million ($7.9 million General Fund) to this figure for a total minimum amount of $36.2 million (General Fund) in state savings. The specifics of this figure are shown below:

- **Reduction of $11 million (General Fund) by reducing by 5 percent** the state's allocation in the Budget Act of 2003.
- **Reduction of $13.3 million** ($6.2 million General Fund) by not providing the medical CPI adjustment in 2003-04.
- **Reduction of $11.6 million** ($5.6 million General Fund) by not providing the medical CPI adjustment in 2002-03.
- **Reduction of $10.4 million** ($5.5 million General /Fund) by not providing the medical CPI adjustment in 2001-02.

Due to the current fiscal situation, it is recommended to adopt the Governor's May Revision proposal. **But as discussed under the EPSDT Program below, it is also recommended to not cost shift any further additional fiscal burden to the counties because these previous years' reductions are now taking their toll in the provision of not providing services and limiting access to services.**

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. DMH,** Is it **factually accurate** that the County MHPs **have not received about $36.2 million in state General Fund support over the past several years?**
- **2. DMH, Please present the May Revision proposal.**

Budget Issue: Does the **Subcommittee want to adopt the May Revision?**

2. Early Periodic Screening Diagnosis and Treatment Program—*Issues "A" to "C"*

Background—Overall: **Most children receive Medi-Cal services through the EPSDT Program**. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) **recipients under age 21 *any* health or mental health service that is medically necessary** to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, **including services not otherwise included in a state's Medicaid (Medi-Cal) Plan.**

Though the DHS is the "single state agency" responsible for the Medi-Cal Program**, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH)**. Further, **counties are responsible for providing, arranging and managing Medi-Cal mental health services under the supervision of the DMH and DHS. However, eligibility and the scope of services to which eligible children are entitled, are *not* established at the local level.**

Types of Services: The state uses the term **"EPSDT supplemental services**" to refer to EPSDT services which are required by federal law **but are not otherwise covered under the state Medi-Cal Plan for adults**. **Examples of services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.**

EPSDT Litigation—State Has Settlement Agreements: In 1990, a national study found that **California ranked 50th** among the states in identifying and treating severely mentally ill children. **Subsequently due to litigation (T.L. v Belshe' 1994)**, the DHS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court's conclusion **was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated.**

Further in January 2004, the U.S. District Court issued an Interim Order clarifying an earlier ruling regarding the provision of TBS that also required outreach, monitoring and related provisions to ensure that children receive EPSDT services as needed. The Court agreed that TBS utilization was too low statewide and ordered the parties to collaborate to develop a plan to increase TBS approvals.

EPSDT Funding Process—Both County and State Funds Used To Draw Federal Match: The DHS and DMH **crafted an interagency agreement in 1995 to implement expanded services as required by the court.**

Generally, this *original* agreement required County MHPs to provide a "baseline" amount using County Realignment Funds (essentially a county "maintenance-of-effort**") and then the state was responsible for providing the nonfederal share of the growth in the program.**

The baseline amount is established for each county based on a formula. For 2004-2005, the baseline is $65.7 million, plus an additional 10 percent county match ($20 million for the budget year) which was instituted in the Budget Act of 2002, for a total of $85.7 million

(County Realignment Funds). The state will provide funding (via Medi-Cal) for costs above this amount (above the baseline and 10 percent match).

The General Fund dollars and accompanying federal matching funds are budgeted in the DHS and are transferred to the DMH as reimbursements. **The DMH distributes EPSDT funds to the County MHPs responsible for the provision of specialty mental health in each county. Final payment is based on cost settled actual allowable costs, or rates.**

Background—Previous Cost Containment Actions: EPSDT is a federal entitlement under the state's Medi-Cal Program. Due to litigation, as discussed under the background section above, the program operates under a settlement agreement with both the state and County MHPs paying the non-federal share of the program. In the Budget Act of 2002, a 10 percent county match on the growth of the total state matching fund requirement above the 2001-02 level was implemented.

In addition, trailer bill legislation accompanying the Budget Act of 2002 required the DMH to ensure statewide application of managed care principles to the EPSDT Program. Regulations to implement this required were endorsed by the Secretary of State in November 2003. It appears that these recent changes may be having an effect on slowing the rate of growth within the EPSDT.

EPSDT Rate of Growth Slow Down: It should also be noted that the rate of growth under EPSDT has shown recent signs of slowing down considerably. **The DMH January budget estimate assumed a growth rate of 16 percent,** ***where as recent actual data for EPSDT shows a growth rate of only 8 percent.***

ISSUES "A" Through "C" begin on the next page.

(The EPSDT restoration of the re-basing issue is under the Vote-Only Calendar)

ISSUE "A"—Revision to EPSDT Program Audits by the DMH

Governor's January Budget Proposal—State Support Item: The Governor's January budget proposed **an increase of $1.7 million ($844,000 General Fund) in state support to hire contractors to conduct additional reviews and oversight of EPSDT Program expenditures.**

The request for funding the contract audit staff originally assumed that over 300 legal entities that provide EPSDT services would be reviewed on a three-year cycle beginning in 2004-05. **This original proposal assumed a sample size representing almost 90 percent of the total paid claims from 2002-03.**

However, the DMH is now changing their selection criteria after meeting with stakeholder organizations. An outline of this revised criteria was discussed in the Subcommittee's May 10th hearing. Generally, the new sampling process will use the following new parameters:

- Will use the April-June 2004 period as the audit period for reviews conducted in 2004-05;
- Will use patient claims, not clients; and
- Will recoup the moneys owed from future payments due to the County MHPs;

This new methodology will involve less workload.

Governor's May Revision—Local Assistance Adjustment: The May Revision proposes changes to the level of reduction anticipated from the EPSDT audits. The DMH notes that in developing the details of the program the January budget calculation certain factors were not adjusted for appropriately. As such, the May Revision proposes an increase of $4.5 million (Reimbursements of which $2.6 million is General Fund from the DHS) to reflect these technical adjustments. **Therefore, it is assumed that these EPSDT audits will result in savings of $3.9 million (General Fund).**

Subcommittee Staff Comment and Recommendation: The DMH has responded to the concerns of the constituencies involved and to the Subcommittee's concerns expressed in the March 22nd hearing. **This is a workable approach that makes sense.** However, one technical adjustment is proposed due to the change in the audit approach. **It is recommended to reduce the state support item by $400,000 ($200,000 General Fund) to account for the change in the workload. This adjustment will serve as a placeholder until staff can meet with the DOF to better calculate the amount.**

Budget Issue: Does the **Subcommittee want to (1)** adopt the May Revision adjustments for the local assistance portion, and **(2)** reduce the state support item by $400,000 ($200,000 General Fund), pending discussions with the DOF?

ISSUE "B"—EPSDT Program—*Proposed Increase to County Match*

Governor's May Revision: The **May Revision reflects a reduction of $98.4 million (Reimbursements from the DHS of which $42.8 million is General Fund) to reflect an updated caseload forecast.** This new estimate is based on more recent data **which projects a 10 percent rate** of growth compared to the 16 percent projected in the Governor's January budget. As such, total expenditures for the program are estimated to be $352.6 million (General Fund) (cash basis). Clearly, existing cost containment measures have curbed some of the EPSDT expenditure growth.

However, the May Revision proposes to save $12.6 million (General Fund) by requiring the County MHPs to increase their share of county participation from 10 percent to 20 percent for counties with a population in excess of 200,000.

Constituency Concerns: The Subcommittee is in receipt of numerous letters articulating **significant concerns with this proposed increased share of county cost.** They contend that such an increase will result in an actual cap on spending in nearly every county. **This is due to the extreme stress county budgets are under including the estimated $300 million in anticipated reductions in mental health services at the county level, which are pending before county Board of Supervisors.**

Subcommittee Staff Comment and Recommendation: It is recommended to adopt the caseload and technical adjustments related to the EPSDT Program **but to reject** the increased shift to the counties. **As such, an increase of $12.6 million (General Fund) is required to backfill for this amount.** As noted under the Mental Health Managed Care item, above, the County MHPs have already sustained substantial reductions to state General Fund support and must already stretch their County Realignment Funding to provide necessary services.

Further, the proposal is flawed policy because it treats all counties the equally, regardless of what their current EPSDT penetration rates are, their cost per child, and their total costs for Medi-Cal recipients.

In addition, it is recommended to adopt the following trailer bill language:

> "No state agency may adopt any policy, restrictions, contract amendments, regulations or other requirements for the provision of mental health services pursuant to the Early and Periodic screening, diagnosis, and treatment program as set forth in subdivision (v) of Section 14132 which shifts a cost from the state to the counties or providers of care or which restricts mental health services eligible for funding under that program unless such state agency action is specifically authorized by statute."

This language will serve as a safeguard that the Administration cannot act unilaterally to institute a higher share of county cost as was done in the Budget Act of 2002.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. Please provide a brief overview of the May Revision proposal.**
- **2. Does the DMH believe the County MHPs can provide this increased level of match and still sustain services to the other populations they are required to serve?**

Budget Issue: Does the **Subcommittee want to (1)** adopt all EPSDT technical adjustments, **(2)** reject the increased shift to the County MHPs and provide an increase of $12.6 million (General Fund) to backfill for the May Revision shift, and **(3)** adopt placeholder trailer bill legislation as noted?

C. Item 4260 Department of Health Services (*Discussion Items*)

MEDI-CAL PROGRAM ISSUES

1. Medi-Cal Baseline Estimate Package

Background on Governor's May Revision: The **Medi-Cal Program local assistance** expenditures **for 2004-05 are estimated to be $27.3 billion ($11.9 billion General Fund),** excluding special funds provided to hospitals through intergovernmental or voluntary governmental transfers. **This reflects a *net* increase of $1.6 billion ($339 million General Fund), based on the Governor's May Revision proposed policy changes.**

Of the proposed $27.3 billion, (1) $25.3 billion is for Medical Care Services, **(2)** $1.731 billion is for County Administration and related items, and **(3)** $311.7 million is for the Fiscal Intermediary.

In addition to these expenditures, a total of $5.4 billion (all special funds and federal funds) is provided to fund payments for Disproportionate Share Hospitals, voluntary governmental transfers for supplemental hospital funding and capital debt projects for hospitals.

Subcommittee Staff Recommendation for Baseline Adjustments: The Governor's May Revision **contains the following key baseline adjustments in which the *Subcommittee staff has raised no issues, or which the Subcommittee has approved through prior action.***

A. Medi-Cal Fee-For-Service Rate Reductions—Rescinded Due to Litigation: As discussed in the **March 8th Subcommittee hearing, litigation has enjoined implementation of the 5 percent rate reduction for fee-for-service Medi-Cal providers that was to occur as of January 1, 2004.** The DHS has appealed this federal court order and contends that they expect to prevail. However, the date of the decision on the appeal is unknown at this time. Further, as discussed in the December 10, 2003 and March 8th Subcommittee hearings, **the Governor had proposed an additional 10 percent rate reduction as part of this Mid-Year Reduction Package.**

The May Revision rescinds the current-year rate reduction of 5 percent for fee-for-service Medi-Cal providers pursuant to the court case, and deletes the additional rate reduction of 10 percent for increased expenditures of about $947 million (General Fund) for the two actions across the eighteen months . It should be noted that the 5 percent reduction, as contained in the Budget Act of 2003, has been applied to Medi-Cal Managed Care plans effective January 1, 2004 for total savings of $123 million ($61.5 million General Fund).

B. Enrollment Caps for Certain Medi-Cal Programs—Rescinded: In his Mid-Year Reduction Package and also in the January budget, the Governor proposed to cap enrollment, effective January 1, 2004, in several Medi-Cal programs. **The Subcommittee rejected these proposed caps in its March 8th hearing. The May Revision conforms to this action by rescinding all of the proposed enrollment caps within Medi-Cal.**

C. Los Angeles County Reconciliation: The May Revision **reduces by $66.7 million ($33.3 million General Fund) to reflect a reconciliation of state and county Medi-Cal eligibility records within Los Angeles County.** Through this reconciliation process, about 130,000 recipients will receive notices that their Medi-Cal eligibility is in question and that they must respond or be terminated from the program. It is assumed that 60 percent, or about 78,000 eligibles are enrolled in managed care and the remaining 52,000 are fee-for-service. Of those enrolled in managed care, it is assumed that 75 percent of the managed care costs will be saved because they will not be eligible for services.

D. County Performance Accountability Standards: A total of $167.2 million ($83.6 million General Fund) will be saved in 2004-05 by having the counties complete re-determinations on a timely basis and holding them accountable through a reduction to their administrative overhead if they are not meeting the statutorily specified performance measures. These standards were enacted as par of SB 26 (First Extraordinary Session), Statutes of 2003.

E. Frequency Limits on Laboratory Services: A total of $10.7 million ($5.4 million General Fund) will be saved in 2004-05 by the DHS placing limits on the number of laboratory tests which could be claimed without prior authorization under the Medi-Cal Program. Once the laboratory limit is reached, additional services would be subject to medical review for determination of medical necessity. This proposal was implemented as part of the Budget Act of 2003.

F. Medical Case Management: Under this on-going activity, nurse case managers coordinate cost-effective services and ensure quality and continuity of care for Medical recipients suffering from chronic or catastrophic illness. A total of $36 million ($8.3 million General Fund) will be saved through this medical management.

G. Emergency Services and Supplemental Payment Funds for Hospitals ("SB 1255"): A total of almost $1.6 billion (special funds) is available to reimburse select hospitals having contracts with the California Medical Assistance Commission (CMAC) to provide enhanced inpatient services. The budget reflects a reduction in payments due to new federal Upper Payment limit restrictions.

H. Medical Education Funds for Teaching Hospitals: A total of $66.2 million (federal funds), is available for certain teaching hospitals for services relating to inpatient clinical teach and medical education activities that are provided to Medi-Cal recipients.

I. Disproportionate Share Hospital Payments: Based on recent federal changes pertaining to the Medicare Prescription Drug Act (HR1), the revised DSH payment for 2004-05 is anticipated to be $2.7 billion ($1.342 billion federal and $1.342 billion special fund). It should be noted that $1.2 million of these funds will be used to conduct an independent audit of program as required by HR1. Further, the state's allocation from these funds remains at $85 million which is used to offset General Fund expenditures in Medi-Cal local assistance.

J. Orthopaedic Hospital Settlement: As required by the settlement agreement, the fourth and final rate increase in Medi-Cal reimbursement for hospital outpatient rates will occur as of July 1, 2004 and will reflect a total adjustment of 43.44 percent over the

2000-01 base period. Total expenditures for 2004-05 for this action are $212.9 million ($106.5 million General Fund).

K. Electromyography & Nerve Conduction: In the April 12th hearing, the Subcommittee adopted this proposal to restrict the billing of these services to neurologists, physicians trained in physical medicine or rehabilitation, or other physicians who have received specialized training in electromyography and nerve conduction tests. Savings of $1.3 million ($652,000 General Fund) are projected for 2004-05.

L. Billing Audits for Medicare Payments: The Budget Act of 2003 provided the DHS with 12 staff to perform additional audit procedures of Nursing Home facilities in order to identify, calculate, and recover the overpayments being made as a result of inappropriate billings and payments relating to Medicare and Medi-Cal crossover recipients. Savings of $15 million ($7.5 million General Fund) are anticipated from these efforts in 2004-05.

M. Increased Personal Injury Recoveries and Estate Recoveries: The Budget Act of 2003 augmented DHS staff by 21 positions to increase the number of cases in which a recovery of Medi-Cal funds is possible due to third-party reimbursement (as in personal injury recovery cases) and estate recoveries. Savings from these two activities is anticipated to be $18 million ($9 million General Fund) in 2004-05.

N. Contracting for Laboratory and Durable Medical Equipment: The Budget Act of 2002 requires the DHS to contract for durable medical equipment and clinical laboratory services. The DHS states that savings of $15.1 million ($7.5 million General Fund) are anticipated for 2004-05.

O. Postage and Printing for Treatment Authorization Requests Processing: The May Revision provides an increase of $300,000 ($150,000 General Fund) for postage and printing.

Budget Issue: Does the Subcommittee **want to adopt the base estimate? This action would align the baseline budget to reflect caseload and all other related adjustments. (Other issues as referenced below will be discussed individually.)**

2. Delay Checkwrite for June 2005 to July 2005 *(Shift to Next Fiscal Year)*

Background and Governor's January Proposed Budget: The Medi-Cal Program provides reimbursement to providers through "checkwrites". Normally there are 52 checkwrites (one per week) per year conducted by the state's fiscal intermediary.

The Governor's January budget proposed to delay by one week the checkwrites for all Medi-Cal Program providers whose claims are processed by the fiscal intermediary (Electronic Data Systems is the contractor). The DHS stated that this one-week delay in the checkwrite would enable the DHS to be more effective in its anti-fraud efforts by allowing the A&I Division to perform a more thorough pre-checkwrite review of claims processed and identified as suspect due to normal billing amounts or trends prior to checks being sent to providers. The DHS stated that if claims appear suspicious, the claims from that provider will be suspended for further review and not included in the payment process. The Governor's January budget **assumed savings of $286.6 million ($143.5 million General Fund)** from this action.

Prior Subcommittee Action (April 12th): The **Subcommittee (1)** adopted the budget proposal to reduce by the amount proposed, and **(2)** reduced by an additional $2 million ($1 million General Fund) to reflect potential savings associated with the DHS identifying savings from their claims review and suspension process.

Governor's May Revision—Delay Checkwrite & Shift A Checkwrite to Next Fiscal Year: The May Revision proposes **(1)** to implement the proposal to delay a checkwrite as contained in his January budget for updated savings of $287.4 million ($143.9 million General Fund), and **(2)** shift the June 2005 checkwrite to July 2005 for additional savings of $286 million ($143 million). The providers would still receive their Medi-Cal reimbursement but it would be delayed by no more than one week. It should be noted that under this proposal, the 2004-05 fiscal year would contain a total of 50 checkwrites (versus the standard 52) and that the 2005-06 fiscal year payments would be increased in recognition of this cost shift.

Subcommittee Staff Comment and Recommendation: It is recommended to **(1)** adopt the Governor's May Revision, ***and*** **(2)** continue the Subcommittee's prior action to recognize an additional $2 million ($1 million General Fund) to reflect potential savings associated with the DHS identifying savings from their claims review and suspension process.

Subcommittee Request and Question: The Subcommittee has requested the DHS to respond to the following questions:

- Please briefly explain the May Revision proposal.

Budget Issue: Does the Subcommittee want to adopt the May Revision and recognize the additional $2 million (total funds) in savings?

3. Non-Contract Hospitals—10 Percent Interim Rate *(See Hand Out)*

Background: There are about **440 licensed hospitals in California. Medi-Cal pays about $3.5 billion (total funds) for inpatient hospital services annually of which 20 percent or $700 million (total funds) is paid to "non-contract" hospitals.**

Non-contract **hospitals** are those who provide inpatient services to Medi-Cal patients but do not operate under a contract with the California Medical Assistance Commission (CMAC).

Each non-contract hospital is paid an "interim payment" by the DHS. The interim payment provides payments for services provided through the hospitals' fiscal year. The interim rate, which is what the payment is based upon, is calculated closely to approximate the cost for providing services to Medi-Cal recipients. These costs are then reconciled using hospital cost reports within five months of the end of a hospital's fiscal year. If the costs of providing services is greater than the interim payment, the hospital is reimbursed the difference. If costs are lower, the hospital must reimburse the difference to Medi-Cal. **The DHS states that while there is an attempt to approximate cost with the interim rate, in practice, many hospitals are overpaid during the course of the year.**

Governor's January Budget: The January budget proposed to reduce interim hospital payments for acute inpatient services **by ten percent effective December 1, 2003.** As such, savings of **$36.2 million ($18.1 million General Fund) for 2003-04, and savings of $62 million ($31 million General Fund) for 2004-05 were assumed.**

Prior Subcommittee Action (April 12th): The Subcommittee adopted the January budget proposal as requested.

Governor's May Revision: The May Revision continues the proposal **to reduce interim hospital payments for acute inpatient services by ten percent, but it changes the effective date to September 1, 2004** ***and*** **proposes trailer bill language for implementation purposes. Savings from this proposal are now assumed to be $57.3 million ($28.6 million General Fund) for 2004-05 with no savings attributed to the current year.**

It should be noted that the savings from this proposal may be temporary because audits performed in 2005-06 may reveal that costs exceeded the new reduced interim payments, thus causing additional funds to be paid to the hospitals in 2005-06.

Subcommittee Request and Question: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly explain the May Revision, including the new trailer bill language.

Subcommittee Staff Comment and Recommendation: It is recommended to adopt the May Revision with modified trailer bill language to serve as a placeholder in order to adjust for technical changes to the language.

Budget Issue: Does the Subcommittee **want to adopt the Subcommittee staff recommendation** as noted above?

4. Three Percent Rate Adjustment-- County Organized Health Systems (COHS)

Background: The COHS model, the oldest of the three models used in California, was first implemented in 1982 in Santa Barbara and San Mateo counties. **Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients.**

Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model). COHS provide a broad range of covered services, including physician, hospital and pharmacy, and also provide some services not covered by the other Medi-Cal Managed Care plans—such as the nursing facility room and board benefit.

About 540,000 Medi-Cal recipients receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about nine percent of all Medi-Cal enrollees. The COHS plans are subject to licensure under the Knox-Keene Health Care Service Plan Act by the Department of Managed Health Care (DMHC). As such, they are obligated to meet certain state requirements meant to ensure financial stability and solvency in order to continue in operation.

Prior Subcommittee Hearing Action (April 12th): In the April 12th hearing, the Subcommittee discussed concerns regarding the fiscal solvency of the COHS and heard detailed testimony from the plans themselves. Specifically, all of the COHS expressed concerns regarding the tenuous nature of their financial viability due to the low level of capitation rates, particularly since they provide services to their aged, blind and disabled populations as well. **As such, the Subcommittee requested the DHS to report back to the Subcommittee regarding options for assisting the COHS to achieve fiscal stability.**

Governor's May Revision: The May Revision proposes **an increase of $30.3 million ($15.1 million General Fund) to provide the County Organized Health Systems with a rate** increase of about 3 percent. The rate adjustment would be effective with each plan's 2004-05 rate period as follows:

• CalOPTIMA	10/1/04	Health Plan of San Mateo	7/1/04
• Santa Barbara Regional	1/1/05	Partnership Health Plan	5/1/05
• Central Coast Alliance	1/1/05		

Budget Issue: Does the **Subcommittee want to adopt the May Revision?**

5. Quality Assessment Fee for Managed Care Plans *(See Hand Out)--Update*

Background: California utilizes several Medi-Cal Managed Care models for the delivery of health care services, including County Organized Health Care Systems (COHS), the Two Plan model (local initiatives and commercial HMOs), and Geographic Managed Care. **The DHS presently contracts with 31 health plans, many of which are considered *non-public* agencies.**

Under both state and federal requirements, the capitation rates paid under a managed care model must be below the fee-for-service cost equivalent. The rates paid to Medi-Cal Managed Care plans were frozen for the past two years and in the current year (2003-04) a five percent reduction is being enacted as of January 1, 2004.

Under the authority of the Social Security Act, Title 19, Section 1903(w)(7)(A), the state may impose a "quality assessment fee" on managed care contracts providing services under the Medicaid Program (Medi-Cal in California). **This mechanism can be used to then draw down additional federal funds.**

Budget Act of 2003: The Budget Act of 2003, and accompanying trailer bill language, assumed implementation of a "quality assessment fee" for Medi-Cal Managed Care plans and savings of $75 million (General Fund) from this effort. **However implementation issues arose in discussions with the federal Center for Medicare and Medicaid (CMS) as well as with some of the plans.**

Governor's January Budget (Assumed July 2004 Implementation): The Governor proposed to implement a quality improvement assessment fee on Managed Care plans as of July 1, 2004 in the same manner as approved by the Legislature last year. **The net affect of this proposal would be to increase the rates paid to Medi-Cal Managed Care plans and save General Fund support.** Under the proposal the DHS would assess a quality assurance **fee of 6 percent** on all Medi-Cal Managed Care plans (Two Plan model, Geographic Managed Care and COHS). **The amount actual paid by each plan would vary, depending on their gross Medi-Cal revenue.**

The quality assessment fee would then be used to (1) obtain increased federal funds to provide a rate adjustment for Medical Managed Care plans, and (2) obtain increased funds to offset about $75 million in General Fund support (*assumed a July 1, 2004 start date*).

Prior Subcommittee Hearing (April 12th): The Subcommittee discussed this issue and accepted public testimony. It was agreed by most Members that this proposal had both fiscal and policy merit. **The only unresolved pertained to trailer bill language.**

Governor's May Revision (Assumes January 1, 2005 Implementation): The May Revision proposes the same basic framework as the Governor's January budget proposal, **except that an implementation date of January 1, 2005 is assumed and therefore, net General Fund savings of only $12.5 million (General Fund). In addition, proposed trailer bill language has evolved as discussions with interested parties have progressed.**

Specifically, trailer bill language is needed as follows *(See Hand Out):*

- Trailer bill language from the Administration (as modified on May 14th) (See Attachment);
- Trailer bill language which clarifies that total operating revenue does not include amounts received by a managed care plan pursuant to a subcontract with Medi-Cal (See Attachment); and
- Trailer bill language which provides a technical adjustment to accommodate a limited liability company which provides Medi-Cal Managed Care services (See Attachment);

These pieces are needed to clarify how the Quality Improvement Fee would operate.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly** present the **May Revision proposal** to implement a quality assessment fee for Medi-Cal Managed Care plans.
- **2. Please step through the proposed trailer bill language.**

Budget Issue: Does the Subcommittee want to **(1)** adopt May Revision fiscal assumptions, and **(2)** the proposed pieces of trailer bill language as noted above?

6. Adult Day Health Centers—(a) Moratorium, (b) Waiver, (c) Rate Reduction

Background Over All—Existing Program: Adult Day Health Care (ADHC) is a community-based day program which provides nursing, physical therapy, occupational therapy, speech therapy, meals transportation, social services, personal care, activities and supervision designed for low-income elders and younger disabled adults who are *at risk* for being placed in a nursing home.

ADHC has been a successful model for elderly individuals for they can obtain many services in one location. For these individuals, particularly those with mobility challenges, going to one place for health care results in better compliance with therapy, medication, nutrition, and exercise regimens. Under Medi-Cal, individuals can participate in ADHC from one to five days per week, but usually average about three days a week.

The general concept behind providing ADHC services is that they delay or defer individuals from going into nursing homes or other more costly forms of care and therefore, it saves Medi-Cal money**.** Compared to the monthly Medi-Cal cost of a nursing home at about $3,400 per month, ADHC can cost as much as three to four times less.

Currently, there are about **37,940 Medi-Cal recipients who receive ADHC services** in any given month. This figure is anticipated to increase to be about 46,400 participants, or about 8,460 new participants enrolled over the upcoming fiscal year. ADHC participants must be approved by a Medi-Cal field office using "treatment authorization requests" (TAR) processes for the ADHC facility to receive Medi-Cal reimbursement.

Further, there are about 300 ADHC facilities in the state who are certified in the Medi-Cal Program. Typically, each ADHC has the capacity to serve between 40 and 100 clients per day. According to the LAO, about 56 percent of the total number of ADHCs were located in Los Angeles County.

Background—ADHC Facility Application Process: In order to become an ADHC provider, there are many steps that are required to be met, including the following:

- Complete a prospective Provider Application and submit to the state in order to obtain licensing and certification approval.
- Obtain a facility site and secure qualified staff in preparation of obtaining approval.
- Field work is completed by the state and licensing and certification is approved. The applicant is now a certified Medi-Cal provider.

Recent Concerns with ADHC Growth: Both the DHS and the California Association for Adult Day Services (Association) have noted that the ADHC Program began to grow in 1999 after many years of exceedingly slow growth. Generally, some of the reasons for this growth included: (1) changes in the state's aging and immigrant demographics, and (2) the lifting of statutory restrictions against "for profit" ADHC providers.

Background on Rates: Currently Medi-Cal reimburses **ADHCs at a "bundled rate"—a single rate which is paid per recipient, per day (minimum of a four-hour stay required).** This rate

includes payment for all required ADHC services as specified in Title 22, California Code of Regulations. **This rate is set at 90 percent of the state's reimbursement rate for Nursing Facility—Level A ($69.58 per day).** This rate structure **was the outcome of a legal settlement agreement done in 1993. This list of required services includes, among other, physical therapy, occupational therapy, speech therapy and recipient transportation to and from the ADHC facility.**

Background Over All--Federal Government Direction To Do a Waiver: In a letter dated December 11, 2003, the federal CMS notified the state that California needs to submit a federal Waiver (1115 or 1915 (c)) in order to continue to receive federal financial participation (i.e., federal matching funds) for ADHC recipients and services. The federal CMS has made it clear that changes to eligibility, the services offered, and the reimbursement methodology will likely need to be made under a Waiver. Transitioning to a Waiver Program will require considerable fore thought particularly given federal requirements pertaining to cost-neutrality, eligibility, service structure and relates aspects.

As discussed in a recent Senate Health and Human Services Committee informational hearing on the ADHC Program, considerable work will need to be undertaken to work through core program issues before a Waiver can be submitted and approved, including policy bill legislation.

Governor's May Revision—Three Issues Intertwined: The **May Revision proposes three significant changes to the ADHC Program. Specifically, these three issues are as follows:**

- ***Trailer Bill Language—Implement a Waiver:*** The Administration has proposed trailer bill language to redesign the ADHC Program by submitting a Home and Community-Based Waiver (1915 (c)).
- ***Moratorium & Rate Redesign ("unbundling"):*** The Administration is proposing trailer bill legislation to implement a **moratorium on the growth of new ADHC sites effective October 1, 2004. In addition, no requested increase to the licensed capacity at existing ADHC centers will be approved. Trailer bill language is also proposed to unbundle the current all-inclusive per diem rate.**

  The May Revision assumes savings of $24.9 million ($12.5 million General Fund) for implementation of the moratorium, and $4.4 million ($2.2 million General Fund) for the proposed unbundling of the rate.

The baseline funding for ADHC is proposed to be $386.4 million ($193.2 million General Fund). This baseline level assumes that 8,400 participants are added over the course of the year.

However, Subcommittee staff has questioned the level of the proposed growth rate contained in the baseline funding because the processing of ADHC applications for licensing and certification purposes has been considerably backlogged. According to the DHS, there are currently 141 ADHC applications depending state review for licensing and certification purposes. The state cannot and will not provide reimbursement under the Medi-Cal Program unless a facility has been certified (i.e., has meet the criteria for Medi-Cal enrollment to

provide services). As such, if ADHC sites are not being certified, they cannot provide services to Medi-Cal recipients (but could serve third-party payers and others).

Based on updated information obtained from the Administration regarding new data on the number of estimated ADHC facilities to be licensed and certified, it appears that the baseline level should be reduced and the savings for the moratorium should be reduced as follows:

Category	New Facilities Per Year	Total Funds	General Funds
Base Estimate:			
• May Estimate	60	$386,458,000	$193,229,000
• Revised Calculation	**30**	$362,615,000	$181,308,000
• **Difference**	**30**	**($23,843,000)**	**($11,921,000)**
Moratorium			
• May Estimate		($16,769,000)	($8,385,000)
• Revised Calculation		($9,246,000)	($4,623,000)
• **Difference**		**$7,523,000**	**$3,762,000**
Net Change *(More Savings)*		**($16,320,000)**	**($8,159,000)**

Subcommittee Staff Comment and Recommendation: It is **recommend to (1)** adopt the ***revised*** fiscal amounts for the baseline and the moratorium since this represents a more accurate depiction of 2004-05 at this time, **(2)** delete the Waiver language from trailer bill legislation and refer it to the policy committee process, and **(3)** adopt placeholder trailer bill language regarding the moratorium (recognizing that work needs to continue).

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly describe each of the three May Revision changes—the Waiver, moratorium and rate redesign.
- **2.** In the view of the Administration, could the Waiver proposal be crafted via the policy committee process?
- **3. Please describe the updated estimate based on new data.**

Budget Issue: Does the Subcommittee want to **(1)** delete the Waiver language from the trailer bill legislation and refer it to the policy committee process, **(2)** adopt placeholder trailer bill language regarding the moratorium (recognizing that work needs to continue), **(3)** adopt the revised fiscal amount as shown in the chart for the baseline and moratorium amounts, and **(4)** adopt the May Revision fiscal amount for the rate unbundling.

7. Governor's May Revision Proposal to Adjust Pharmacy Reimbursement *(See Hand Out)*

Background—Existing Medi-Cal Reimbursement: Existing federal and state statute require that Medi-Cal base its reimbursement for drugs **on an amount that is "the Department's best estimate of the price generally and currently paid by providers for a drug product sold by a particular manufacturer or principal labeler in a standard package** (Section 14105.46 of W & I Code).

Generally, the DHS calculates **Pharmacy reimbursement based on a formula that has two basic components: (1) a professional dispensing fee, and (2) a drug ingredient costs.** This is the maximum rate that can be paid because in some instances a provider bills the Medi-Cal Program a "usual and customary amount" that is lower than this calculated amount. **In addition, the DHS reduces every drug claim by 50 cents (10 cents if the Medi-Cal recipient is in a nursing facility).**

Medi-Cal's **dispensing fee of $4.05 has not changed since 1986 and reductions of 10 to 50 cents per claim continue as a cost-cutting measure in the Medi-Cal Program.**

Currently, the reimbursement level for the drug ingredient cost is the lowest of the (1) Federal Acquisition Cost, **(2)** state Maximum Allowable Ingredient Cost (MAIC), **(3)** Average Wholesale Price (AWP) minus 10 percent, ***or*** **(4)** Average Selling Price (ASP)

The DHS notes that current reimbursement formulas, such as Medi-Cal's existing AWP minus 10 percent plus the dispensing fee, traditionally have over-reimbursed the drug ingredient component and under reimbursed the professional fee. This was made evident in the department's contracted study regarding Medi-Cal pharmacy reimbursement (2002). This study showed that the weighted mean cost to dispense a prescription in 2000 was $7.21 per prescription (versus the $4.05 paid by Medi-Cal). **The study also indicated that the DHS was significantly over paying on the drug ingredient portion of the reimbursement, both for brand name drugs and generic drugs.**

The DHS also notes that the California Attorney General's Office (AG's Office) announced that **the use of Average Wholesale Price (AWP) as a price indicator will be eliminated in the near future in favor of a different price reference number, such as Average Selling Price (ASP). The AWP is now viewed as a fictitious number (much like the manufacturers suggested retail price for automobiles).**

However, the use of AWP has been and continues to be the dominant pricing approach used by virtually all third-party payers because other pricing information, such as Average Selling Price, is not yet widely available.

Governor's May Revision: The May Revision **proposes a reduction of $158.5 million** ($79.3 million General Fund) by **(1)** implementing **a new acquisition rate for prescription and over-the-counter drugs**, ***and*** **(2)** providing **an increase in the professional dispensing fee**. The May

Revision assumes implementation of this action **by September 1, 2004**. **This proposed action also requires statutory change** ***(See Hand Out).***

The ***net annual*** **savings are anticipated to be about $200 million (total funds). This is derived as follows:**

- **Increase the dispensing fee** from $4.05 to **$8.30** and eliminate the 50 cent/10 cent reduction to each claim. **This results in expenditures of about $243 million** (total funds).
- Changes the drug ingredient cost **from AWP minus 10 percent to AWP minus 20 percent, or the Average Selling Price (ASP)**

The new drug ingredient rate of AWP minus 20 percent is proposed as a single, blended rate, meaning that there would be no distinction between brand name drugs and generics. The DHS states that AWP minus 20 percent is still significantly higher than the pharmacy acquisition cost of generic drugs. However, it is much closer to the price a pharmacy pays for brand name drugs, which account for the majority of expenditures (nearly 80 percent) in the Medi-Cal program. **According to First Data Bank, the department's source for AWP pricing, AWP minus 20 percent is a much better estimate of the "price generally and currently paid by providers for a drug."**

The DHS also conducted an analysis of the dispensing fee. Based on the 2000 study (as previously referenced), as well as statistics from the Bureau of Labor Statistics information on the historical trend change in professional specialty and technical occupations (which includes Pharmacists), the DHS states that a 13.5 percent increase should be applied to the $7.21 cost to dispense a prescription (shown as the cost in the 2000 study). Adding in a 1.5 percent margin (i.e., 15 percent), **the dispensing fee amount would be about $8.30.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **provide a summary of the proposal**, including how the dispensing fee amount was derived as well as the proposed drug ingredient change (AWP minus 20 percent).
- **2.** Please **briefly describe the proposed trailer bill language**.

Budget Issue: Does the Subcommittee want to adopt or modify the May Revision request?

8. Trailer Bill Language for Medical Supplies to Parallel Pharmacy Concept *(See Hand Out)*

Governor's May Revision: The **May Revision proposes trailer bill language to (1)** repeal Section 14105.2 of Welfare and Institutions Code pertaining to the markup allowed for dispensing of medical supplies, and **(2) add** a new Section 14105.2 of Welfare and Institutions Code which parallels pharmacy language regarding Average Selling Price (See Attachment.). **The *May Revision does not identify any savings* associated with this trailer bill proposal.**

The existing provision proposed for repeal is as follows:

Repeal Section 14105.2 of Welfare and Institutions Code:
~~(a) The allowable markup payable for the dispensing of medical supplies by assistive device and sickroom supply dealers and pharmacies shall not exceed 23 percent of the cost of the item dispensed, as defined by the department.~~

~~(b) Payment for diabetic testing supplies shall not exceed the cost of the item dispensed, as defined by the department, plus a fee equal to the maximum professional fee component used in the payment for legend generic drug types.~~

Constituency Concerns: The Subcommittee is in receipt of several letters expressing concerns with this proposal. Among other things, the following is noted by interested parties:

- **No study has been conducted**, nor has a review been done, on the cost of dispensing medical supplies, as was done with the pharmacy reimbursement.
- **Too much authority being provided to the DHS in trailer bill language** so that the DHS can change prices and covered items via a Medi-Cal Provider Bulletin.
- In the Budget Act of 2002, the DHS **was given expanded authority to both contract for disposable medical supplies and diabetic test strips and the mark-up was reduced from 25 to 23 percent**. **The DHS has yet to contract for any supplies other than incontinence supplies** and they have also failed to make diabetic test strips a pharmacy benefit only benefit.
- In the Budget Act of 2002, the DHS requested and was granted authority to establish maximum allowable product costs which were to be based upon the mean of the wholesale selling price. It was not implemented and they now propose another methodology.
- **Medical supplies are relatively inexpensive even when purchased for patients in quantities for 30 to 90 day supply.** Providers who stock and dispense these types of disposable supplies must inventory a variety of sizes and product styles.

Subcommittee Request and Questions: The Subcommittee **has requested the DHS to respond to the following questions:**

- **1.** Please describe the proposed May Revision trailer bill language and why it is needed?
- **2.** Please provide some concrete examples of how the proposed methodology would work and how that is different than existing statute.

- **3.** Is information readily available regarding how one defines the Average Selling Price for medical supply products?

Budget Issue: Does the Subcommittee **want to reject** the proposed trailer bill language?

9. Administration's Proposals Regarding Federally Qualified Health Care Centers (FQHCs) and Rural Health Care Clinics (RHCs)—Significant Changes Proposed

Background—Summary of Federal Law Change and Budget Act of 2001: Prior to 2001, the state provided "cost based" reimbursement for clinics with an FQHC or RHC designation as directed by federal law. Under this "cost based" system, FQHCs and RHCs would submit cost reports, the DHS would review and audit the reports and a cost-settlement process would then determine the final Medi-Cal payment.

Through a federal law change—the Consolidated Appropriations Act of 2001—a new *"Prospective Payment System" (PPS)* was to take effect as of January 1, 2001.

Generally under a PPS, a *base* payment year would be established to pay a FQHC's/RHC's average reasonable cost. Then beginning in federal fiscal year 2002 and for each year thereafter, each FQHC/RHC would receive the *per visit base payment* increased by the percentage in the federal Medicare Economic Index (MEI) for primary care services, *and* adjusted to take into account any increase or decrease in the "scope of services".

As such, the clinic would be paid up front and, when applicable, a cost adjustment (i.e., MEI) would be provided along with any service level adjustment (i.e., scope of service changes). The purpose of this federal law was to drive increased efficiencies at the clinic level and to make program expenditures more predictable.

Under this federal law change, a state could also utilize an *"Alternative Payment Methodology"* in lieu of PPS, if certain conditions were met.

Background--California's Choice: **As discussed below, California opted to implement *both* a PPS and an Alternative Payment Method.** The state adopted the Alternative Payment Method as a compromise.

The key components to the agreed to state's process are: (1) establishment of a base payment rate (i.e., clinic selects either a PPS or alternative payment), (2) adjust future payments as appropriate using the MEI, *and* (3) adjust future payments as appropriate based on "scope of service" changes.

Budget Act of 2001 and Specifics of California's Agreement: Through the Budget Act of 2001 and subsequent legislation—SB 36 (Chesbro), Statutes of 2003—**California submitted a State Plan Amendment to the federal CMS for the state's PPS *and* Alternative Payment Methodology. Clinics were given the option of selecting either** the PPS method of

reimbursement or the Alternative Method of reimbursement **for establishing a *base* rate per clinic visit.**

Under California's agreement, the following framework was established:

- **PPS *Base* Reimbursement:** This methodology consists of taking a FQHCs/RHCs 1999 and 2000 cost reported data and calculating an average cost per visit from the two fiscal years.

- **Alternative *Base* Reimbursement:** This methodology consists of utilizing 2000 cost reported data and calculating an average cost per visit from this year alone. About **67 percent of the FQHCs/RHCs chose this base reimbursement method**.

- **Medicare Economic Index:** As contained in federal law, a FQHC's/RHC's base reimbursement (either PPS or the Alternative Method) would be adjusted by the Medicare Economic Index (MEI), effective each federal fiscal year (commencing with October 1, 2001).

- **Scope of Service Change (80/20 Method):** As contained in federal law and state law, an adjustment in the reimbursement rate is required whenever a FQHC/RHC has a "scope of service" change. **A scope of service change is defined *as an addition or deletion of a service or a change in the type, intensity, duration, or amount of services.***

  All scope of service changes must first be documented by the FQHC/RHC and approved by the DHS. Further, because of the complexity in trying to measure the appropriate dollar amount assigned to the scope of service change, a methodology was developed—the "80/20" method.

  Generally under the "80/20" method, *only* 80 percent of the cost difference from the previous fiscal year to the scope of service fiscal year is attributable to the scope of service change. The remaining 20 percent of the cost change is assumed to be normal operating increases. As such, the scope of service change is discounted from the beginning.

- **Managed Care Differential:** DHS is required to reimburse FQHCs/RHCs that provide services to Medi-Cal recipients enrolled in Managed Care Plans (Plan) an amount up to the FQHC's/RHC's PPS rate for all billable services rendered to the applicable recipients. Since the rate paid by the Plan is lower than the PPS rate, an interim rate is paid. Final reconciliation will identify the remaining differential payment that needs to be paid to the FQHCs/RHCs.

- **Medicare/Medi-Cal Crossovers:** DHS is required to reimburse FQHCs/RHCs that provide services to Medicare/Medi-Cal recipients an amount up to the FQHC's/RHC's PPS rate for all billable services rendered to the Medicare/Medi-Cal recipient. Since the rate paid by Medicare is lower than the PPS rate, an interim rate is currently paid to the FQHC/RHCs to make up for part of the difference between what Medicare pays and the PPS rate. Final reconciliation will identify the remaining differential payment that needs to be paid to facilities.

Status of the State's PPS and Alternative Payment Method—Not Yet Implemented: First, the state's PPS, including the Alternative Rate Method, that has **been under development since 2001 has not yet been fully implemented. Though clinics have effectuated scope of service changes, the DHS has not calculated the "scope of service" changes since the forms and process for calculating them were just recently completed. Federal approval of this process, as submitted in a State Plan Amendment in January 2004, is still pending.**

Therefore, the state is in arrears for paying the FQHCs/RHCs for Medi-Cal Program services provided in past years in many areas, including (1) scope of service changes, (2) MEI adjustments, (3) Managed Care adjustments, and (4) Medicare Crossover payments.

***As estimated by the DHS*, these in arrears payments that the state owes the clinics is about $115 million (total funds), *plus* ongoing expenditures for 2004-05. (See Chart below.)**

Governor's May Revision: The **May Revision contains several adjustments as shown in the table below. Each of these issues is then discussed further below.**

Summary Chart: Policy Changes Shown on *Cash Basis* (cash paid out in that year)

Component	2004-05 (January) (Total Funds)	2004-05 (May) (Total Funds)	Difference (Rounded)
1. Medicare Economic Index (MEI)	$31.9 million	$31.4 million	($600,000)
2. Scope of Service Change			
• Retroactive	$95.6 million	$56.8 million	($38.8 million)
• Ongoing	$19.9 million	N/A	($19.9 million)
• Ongoing—impact of retro		$17.7 million	$17.7 million
• Ongoing—new scope changes		$6.7 million	$6.7 million
3. Managed Care			
• Retroactive	$33 million	$33.8 million	$800,000
• Ongoing	$22.3 million	--	($22.3 million)
4. Medicare Crossovers			
• Retroactive	$29.2 million	$23.2 million	($6 million)
• Ongoing	$4.7 million		($4.7 million)
5. Audit Savings Adjustment	$10 million	$10 million	--
6. Eliminate Alternative Method	($64.5 million)	($9.8 million)	$54.7 million
• **TOTALS**	**$182.3 million**	**$169.9 million**	**($12.4 million)**

- ***Eliminates Alternative Rate Methodology:*** The **May Revision** continues the Governor's January Budget proposal to **eliminate the Alternative Rate Method, effective October 2004, for identified savings of $9.8 million ($4.9 million General Fund).** This savings level is substantially less than proposed in January for two reasons. It assumes an October elimination date, versus an April date, and it assumes that fewer clinics will have a scope of service change (68 percent now). Generally, newer clinics will be most impacted by this elimination. **In the March 8th hearing, the Subcommittee rejected this proposal.** It should be noted that the DHS contends that they can proceed with a unilateral elimination of this method via a State Plan Amendment but has withheld this action until closure of the budget.

- ***Scope of Service Changes:*** The May Revision reflects **an increase of $81.2 million** ($40.6 million General Fund) for the scope of services changes (retroactive and ongoing). Most of this amount is for retroactive payments. **The May Revision also assumes that 100 percent of the retroactive payments for January 2001 through June 30, 2004 will be paid in 2004-05.**

- ***Other Factors—MEI, Medicare Crossovers, Managed Care:*** These three areas reflect relatively minor technical adjustments. No issues have been raised for these factors.

Significant Constituency Concerns: The Subcommittee is in receipt of letters which express significant concern **regarding the lack of implementation for the scope of service changes and the proposed elimination of the Alternative Rate Method.**

The proposed elimination of the Alternative Rate Method is very significant. They note that federal law sets a payment floor for FQHCs/RHCs (i.e., the minimum federal payment) and provides that states are free to adopt any equivalent or more generous payment methodology so long as a clinic consents to the alternative. California is not currently in a position to calculate the minimum federal payment because it has not yet calculated the scope of service changes which have occurred since 2001. **It is strongly desired to have the scope of services changes implemented and fully paid in 2004-05, along with other payments that are retroactively owed.**

Further it is noted that the existing agreement—choice of the PPS base payment or Alternative Payment Method—was an agreed to compromise which has clearly not been enacted, and yet, the state now wants to change the deal.

Subcommittee Staff Comment and Recommendation: As noted in the discussion above, implementation of the entire **Prospective Payment System/Alternative Rate Method is still pending almost four years later. However the DHS has been facilitating several meetings with interested parties to finalize the necessary forms and processes, and to reconcile fiscal estimates. The department has moved along considerably and should be commended for convening these meetings to reconcile differences.**

Based on discussions between the DHS and constituency groups, the following action is recommended:

- **1. Retain the prior Subcommittee action to reject the Administration's proposal to eliminate the Alternative Payment Method, but use the updated May Revision figure.** As such an increase of $9.8 million ($4.9 million General Fund) is required.
- **2. Adopt uncodified trailer bill legislation to recognize the Administration's intent to pay 100 percent of retroactive payments for January 1, 2004 through June 30, 2004 in fiscal year 2004-05. Suggested language is as follows:** It is the Legislature's intent that retroactive payments owed to Federally Qualified Health Centers and Rural Health Centers for the period that began January 1, 2001 and proceeds through June 30, 2004, shall be made in the 2004-05 fiscal year.
- **3. Adopt trailer bill legislation to facilitate implementation of the scope of service changes.** Suggested language is as follows:

  - **Add Section 14132.105 to Welfare and Institutions Code:**

  (a) The director may adopt emergency regulations to implement Section 14132.1 of the Welfare and Institutions Code in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

  (b) The adoption of emergency regulations described in subdivision (a) shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filling with the Secretary of State and publication in the California Code of Regulations.

  (c) Notwithstanding subdivisions (a) and (b), the director may issue such instructions and forms that are consistent with and necessary to implement subdivisions (e), (f), (h) and (i) of Section 14132.100 of the Welfare and Institutions Code, and Sections (A) and (D) through (L), at pages 6 through 6R of Attachment 4.19-B to The California Medicaid State Plan in effect on January 1, 2003, relating to the reimbursement rate methodologies for federally qualified health center services and rural health clinic services. Adoption of such instructions and forms shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of title 2 of the Government Code). Actions pursuant to this subdivision must be taken within 30 days following the date that this section becomes effective.

  (d) The authority to grant emergency or expedited regulations under this section expires on June 30,2006.

- **Add Section 14132.107 to Welfare and Institutions Code**

14132.107 Claims for reimbursement under subdivisions (e) and (h) of Section 14132.100 shall be finalized by the department within 150 days of receipt, and claims paid within 30 days thereafter, except that payment of those amounts that are disputed shall be subject to the requirements and time frames and procedures set out in Section 14171. Scope changes going forward shall be finalized within 90 days of receipt.

- **Add Section 14132.108 to Welfare and Institutions Code**

Notwithstanding any other provision of law, requests for rate adjustments for scope of service rate changes under paragraph 4 of subdivision (e) of Section 14132.100, for an FQHC's or RHC's fiscal year ending in 2004 shall be deemed to have been filed in a timely manner so long as filed within 90 days following the end of the 150 day time frame applicable to scope of service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year, as set out in paragraph (6) of subdivision (e) of Section 14132.00

- **4. Adopt trailer bill language to clarify how consolidated cost reports will be handled. Suggested language is as follows:**

Delete (D) from Section 14131.100 as follows:
~~(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHC's and RHC's filing consolidated cost reports for multiple sites, the FQHC's or RHC's rate equals or exceeds the lesser of 1.75 percent or ten thousands dollars ($10,000), on a aggregated basis. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.~~

Insert new (D) for Section 14131.100 as follows:

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold shall be applied to the average per visit rate of all sites for the purposes of calculating the cost associated with a scope-of –service change.

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to respond to the following questions:

- **1. Please provide a brief summary of the May Revision.**
- **2. Please explain how the DHS calculated the scope of service change information when actual data is currently not yet available.**
- **3. Please step through the proposed trailer bill language.**

10. County Administration of Medi-Cal –Proposed Cost Containment

Background—Medi-Cal Eligibility Processing: Each county is responsible for implementing Medi-Cal eligibility and for interpreting state guidance on policies and procedures. Counties determine eligibility for Medi-Cal under a set of complex rules that require staff to collect and verify a variety of information. **In fact, the DHS provides counties with an 800-plus page state Medi-Cal Eligibility Procedures Manual** that is updated on a constant basis through state issued "All County Letters". There are more than **150 aid codes**, and dozens of state Medi-Cal related forms.

Counties are provided with an annual allocation from the state to conduct Medi-Cal Program eligibility processing activities for the state (federal law requires that a governmental entity complete all Medicaid (Medi-Cal) applications). The allocation is contained within the annual Medi-Cal Estimate Package provided to the Legislature as part of the annual budget deliberations.

SB 26 (X1), Statutes of 2003—County Performance Standards: Through SB 26 (First Extra Ordinary Session), Statutes of 2003, the Legislature enacted comprehensive "county performance standards". Under these standards, counties must meet specified criteria regarding completing eligibility determinations and performing timely re-determinations. Specific work standards—including timeframes and percentages that need to be completed—are outlined in the enabling statute. **If a county does not meet these performance standards, their administrative funding may be reduced by up to two percent as determined by the Department of Health Services.** Further, implementation of a corrective action plan in those counties that fail to meet one or more of the standards is required. **As noted under the Medi-Cal baseline estimate discussion in this agenda (See Item 1, above), continued implementation of the county performance standards is estimated to save $229 million ($114.5 million General Fund) in 2004-05.**

Further, the DHS was provided 9 new positions in 2004-05 to implement and monitor the County Performance Standards.

Governor's May Revision: The May Revision **proposes to reduce County Administrative expenditures by $46.8 million ($23.4 million General Fund) by implementing a "cost control" plan to limit the growth in allocations associated with Medi-Cal eligibility determinations. The DHS states that the initial phase of this proposed plan would be in effect for the 2004-05 allocation process.**

The DHS contends that the purpose of this plan is to ensure that counties have sufficient staff to complete required eligibility activities and annual re-determination in the most cost-effective manner. **Further they note that as the plan is developed, it is suppose to include staffing guidelines, policies to control overhead costs, and the ability to limit county employee wage costs, while still maintaining the integrity of the eligibility determination process.**

The **Administration has proposed Budget Bill Language** as part of this proposal. The proposed language is as follows:

> **"**In ***any*** given fiscal year, allocations to accommodate county wage increases shall not exceed the average COLA granted to State workers or the California Necessities Index, whichever is greater.**"**

Subcommittee Staff Comment and Recommendation: First, the May Revision makes reference to the DHS developing a "cost containment" plan. **However, no plan has been presented to the Legislature and it is unclear as to its actual contents. Therefore, it is difficult to discern how the proposed savings will be achieved and what may or may not be needed in future fiscal years to ensure a cost-efficient, high quality Medi-Cal eligibility processing system.**

As such, it is recommended to adopt uncodified trailer bill language in order to have the DHS complete a plan and to provide it to the Legislature. This proposed language is as follows:

> **"**The department, in collaboration with the County Welfare Directors Association shall develop options and recommendations for modifying the budgeting and allocation methodologies for county Medi-Cal administration. The recommendations shall at a minimum consider the number of eligible cases, the complexity of cases, the way in which caseload growth funds are allocated, and the workload associated with denied applications. The department shall consider options for the establishment of productivity features that result in efficient and effective administration of the Medi-Cal program, including accurate and timely determinations of eligibility and redeterminations and reasonable access to eligibility services for potential eligibles. The department shall report their options and recommendations to all fiscal committees of both houses of the Legislature by January 10, 2005."

Second, the Administration's proposed Budget Bill Language is unnecessary and meaningless. The state is under no obligation to fund county COLAs and in fact, has not provided counties with funds for "doing the cost of business" in Medi-Cal on several occasions. Third, with a dollar reduction being taken, there is no statutory language that would require the state to provide an additional amount, other than what is appropriated for this purpose. Lastly, Budget Bill Language is only applicable for one-year, not multiple fiscal years as the language references. If the Administration wants to modify how total costs are determined, it is suggested to more thoroughly discern what the cost drivers are and to work with the counties on an applicable approach with a plan.

Budget Issue: Does the **Subcommittee want to (1) adopt the Administration's May Revision reduction of $46 million (total funds), (2) delete the Administration's Budget Bill Language**, and **(3) adopt trailer bill language as outlined above?**

11. Quarterly Medi-Cal Reconciliation *(See Hand Out)*

Background and Explanation of State's Concerns: Due to **computer processing differences, county eligibility and state eligibility data files can show different Medi-Cal eligibility data. Automated and manual processes exist to minimize the impact of these data discrepancies but they still occur.**

In 1970, **the DHS set up a state Medi-Cal Eligibility Data System (MEDS)** reconciliation process for counties in order to synchronize the state's MEDS and county eligibility changes and eliminate any data discrepancies found on the county and state records **through daily or batch transaction processing to MEDS**. Through this system, **when data discrepancies occur, the state's system issues routine alerts to the counties that are to be worked to correct the data.**

The MEDS reconciliation process compares the records on MEDS with the county files to identify any records on MEDS that are not on the county system. Reconciliations are done on cases that are shown as active on MEDS, but are not shown on the county system as eligible. **Counties are required to manually resolve cases that are newly found to be eligible on MEDS but not eligible on the county system. Counties are given up to 12 months to resolve these data differences manually. According to the DHS, this gives the counties as many as three sequential alerts to correct each discrepancy.**

Presently, the DHS terminates a Medi-Cal eligible record if the person is not eligible on the county file, but is eligible on MEDS, and where there has been no eligibility update on the record in 12 months. The DHS notes that at this time, not all counties properly complete the reconciliation process or work their alerts as required, so some MEDS records are not appropriately being terminated. Therefore, Medi-Cal recipients remain on MEDS for 12 months or more, even though there is not a county record. Medi-Cal Managed Care capitation payments are, therefore, made for persons that the county data system shows as ineligible and there has not been a MEDS transaction for 12 months. Generally, this is what occurred in Los Angeles County, as referenced in this agenda under item 1, above.

Governor's May Revision: The May Revision **proposes (1) a reduction of $18 million ($9 million General Fund) in local assistance funding, (2) trailer bill language to add new statutory provisions regarding county requirements, *and* (3) an augmentation of $100,000 ($50,000 General Fund) to fund a new state staff position (Associate Governmental Program Analyst) to implement and monitor the reconciliation process.**

Among other things, the Administration's proposed trailer bill *(See Hand Out)* would do the following:

- **Shorten the time the state carries an inactive county eligibility record from 12 months to 6 months;**
- Requires counties to work on a **routine basis *any* error alert** from the state's MEDS system within 5 working days;
- Requires the counties **to fix *any* data discrepancies** within 5 working days of receipt of the alert;

- Requires counties to conduct reconciliations every quarter (three months) and in a format as determined solely by the DHS;
- Subjects counties to yet another potential loss of two percent of their county administration funds.

Constituency Concerns—Modify Trailer Bill Language: The County Welfare Directors Association **(CWDA) have provided the Subcommittee with examples of "alerts" which are relatively meaningless, and do not affect an individual's Medi-Cal eligibility.** They note that older automation systems such as **MEDS lack the sophistication to recognize and automatically correct minor discrepancies**, making it necessary to employ an alert-based system and devote scarce county staff resources to this task. **As just one example, San Bernardino receives about 1,000 daily alerts and over 70,000 quarterly alerts.** Further, the same case can generate more than one alert, including both critical and non-critical issues.

Subcommittee Staff Comment and Recommendation (See Hand Out): Though there are many existing automated and manual processes to minimize data discrepancies, **an improved process is warranted due to recent circumstances. However, alternative trailer bill language is recommended which more clearly articulates expectations and focuses on the *key* problem at hand—resolving those alerts that affect eligibility or the share of Medi-Cal cost.**

The DHS Eligibility Quality Control Branch currently has one Staff Services Manager II, three Staff Services Manager I, 15 Analysts and three support staff. Further, the DHS was provided with 9 positions to enact the county performance standards as discussed in the above item. **Yet another position to monitor a function that should be a core responsibility of the department is not recommended.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. DHS, Please present the May Revision proposal, including the trailer bill legislation.**

Budget Issue: Does the **Subcommittee want to (1)** adopt **alternative** trailer bill language, **(2) adopt the May Revision savings level**, and **(3) deny the DHS position** and save an additional $100,000 ($50,000 General Fund)?

12. Validation of Medi-Cal Eligibility—Contingency Contract *(See Hand Out)*

Background: The **DHS states that at least 2 percent of Medi-Cal recipients receive Medi-Cal benefits erroneously.** They contend that most of this is due to difficulties in processing eligibility information between the counties and the state MEDS, as discussed under the agenda item above. **As such, the Administration believes that a Third-party vendor should be hired on a contingency basis to go to counties and complete case reviews to verify that eligibility determinations are done correctly.**

This proposal would be in addition to (1) the codified county performance standards process, and (2) the quarterly data reconciliation process.

Governor's May Revision: The May Revision **proposes savings of $6 million ($3 million General Fund) by contracting with a Third-Party Vendor to review Medi-Cal eligibility determinations made by counties on-site.** The savings level assumes that 9,700 individuals are discontinued from Medi-Cal. Implementation would commence as of March 2005. The proposed savings figure assumes expenditures of $714,000 ($357,000 General Fund) for the contract in 2004-05.

According to the DHS, the contractor would receive a payment for each ineligible person removed from the state's MEDS files for a period exceeding three months. In other words, a potentially ineligible person would be notified by the county and then that person would have to undergo eligibility approval again before three months time, or be removed from the program. If the individual is removed due to said ineligibility, then the Vendor would receive a payment as an incentive. It should be noted that the Vendor would not make any final eligibility determination, but would return to the county any case record findings that the Vendor finds was potentially determined incorrectly.

The proposal also states that the department may charge the counties the fixed-price paid to the Third Party Vendor by reducing the county's Medi-Cal administrative funds.

The Administration is proposing trailer bill language *(See Hand Out)* **that, among other things, would do the following:**

- Provides the DHS with authority to hire a Third-Party Vendor to review and validate county eligibility determinations;
- States that the Third Party Vendor would not make any final determinations of eligibility;
- Requires counties to evaluate any Third Party Vendor finding and to take corrective action accordingly within 15 days of notice by the Vendor;
- Requires the DHS to make any final eligibility determinations if there is a disagreement regarding the validity of eligibility between the county and the Third Party Vendor;
- Specifies that the Third Party Vendor will receive a "fixed-price" for every case for which the Vendor finds that an eligibility determination is made incorrectly as stated;
- Provides that the DHS can charge counties a fixed-price for the contract with the Third Party Vendor by reducing county Medi-Cal administrative funds;

- Grants sole authority to the DHS to conduct a procurement of the Third Party Vendor contract and that the DHS can implement the provisions of the statute through "All County Letters", provider bulletins or generally, any other means that is suitable to the DHS; and
- Directs that the DHS will only implement this action if federal financial participation is available.

Subcommittee Staff Comment and Recommendation: This proposal is flawed and should be denied. **First**, it is unlikely that the federal government would allow for a Third Party Vendor to invalidate a Medi-Cal eligibility determination made by a governmental entity due to the existing federal law structure. The DHS even recognizes this or the federal funding exception provision would not have been added to the proposed trailer bill language.

Second, **there were several significant actions taken last year (i.e., county performance standards, semi-annual eligibility determinations) regarding Medi-Cal eligibility and two more comprehensive proposals in this May Revision. These proposals need to be monitored and implemented appropriately prior to adding on yet another layer of oversight and processing.** Both the county performance standards from last year, as well as the May Revision proposal on quarterly data reconciliation (see above agenda item) also serve as fiscal incentives to the counties due to the potential of loosing 2 percent of their county Medi-Cal administrative funds if certain requirements are not met.

Third, it is likely that some portion of the proposed savings would be negated by increased fair hearings due to questions arising as to one's eligibility.

Fourth, the state needs to also review its own MEDS process to see what improvements can be done—such as system changes for more edits or manual checks—to improve on the other side of the county-state partnership.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please briefly explain the proposal, including how the Third Party Contractor would conduct business and be paid, as well as the trailer bill language.**
- **2. Would the potential contractor be selected through a competitive bid process or other means?**
- **3.** Do you **believe federal approval would be easily granted?**

Budget Issue: Does the **Subcommittee want to reject this proposal?**

13. Federal Medicare Prescription Drug Act Implementation—Request for Staff

Background: The Federal Medicare Prescription Drug, Improvement, and Modernization Act (Act) was signed into law in December 2003. A key component of the Act is that Medicare will take over responsibility for providing prescription drugs for dual eligibles administered through qualified managed care plans. Among other things, states will have the option of covering dual eligibles at state-only expense when the dual eligible does not volunteer for Part D or needs drugs that may be not available through a Part D managed care plan.

The DHS states that they will incur new burdens of responsibility as the infrastructure obligations, eligibility worker training, and other administrative requirements of the Act require implementation. There is no funding for these efforts from the federal government, only the normal state and federal funding can be used.

The DHS states that there are many functions contained in the Act that must be addressed, including the following:

- Require an annual independent audit of Medi-Cal's Disproportionate Share Program for safety net hospitals;
- State legislation is needed to define the Medicare drug benefit as the drug benefit for people on Medi-Cal and Medicare;
- States will be required to finance much of the drug coverage for dual eligibles through the federal "clawback" requirement;
- States, via the counties, will be responsible for screening to determine premium and cost-sharing subsidies for low-income beneficiaries' eligibility.

Governor's May Revision: The May Revision is requesting **an increase of $437,000 ($151,000** General Fund) **to hire 5 new state staff and make changes to the Medi-Cal Eligibility Data System (MEDS)** to implement provisions of the Act. Specifically, the DHS states the following needs:

- Contractor funding for information technology services to add data elements to identify, track, and report on full-benefit dual eligibles in the amount of $308,000 (total funds) is requested.
- Contractor funding is needed to secure a contractor for the required annual, independent audit of Medi-Cal's Disproportionate Share Hospital Program for safety net hospitals. (This issue is addressed in the Medi-Cal local assistance item.)
- Funding for state positions is requested. The positions include: Two Analysts (two-year limited-term), one Health Program Auditor III (two-year limited-term), one Associate Information Systems Analyst (two-year, limited-term), and one Analyst (permanent).

Legislative Analyst's Office: Based on their initial review, the **LAO is not convinced that all of the requested positions are justified.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly describe the May Revision and the need for the requested resources.
- **2.** Why do all of these resources need to be provided in 2004-05?

Budget Issue: Does the Subcommittee want to modify or adopt the request for staff and contracting resources?

14. Proposed New Automated System to Track/Cost Monitor the Fiscal Intermediary Contract

Background: The state contracts with Electronic Data Systems (EDS) to perform the fiscal intermediary functions for the Medi-Cal Program, including claims processing services. **According to the LAO, state payments to EDS have risen about 23 percent a year during each of the last five years. Total payments to EDS are expected to be $232 million ($69 million General Fund) in 2004-05.**

Department of Finance, Office of State Audits & Evaluations—June 2003 Audit Findings: The DOF conducted an audit of the EDS contract last year because of concerns about the growing scope, size, complexity, and cost of the California Medicare/Medi-Cal Information Systems (MMIS)—the information technology system maintained and operated by the EDS to carry out its fiscal intermediary functions.

The DOF audit found weaknesses in DHS' oversight of the EDS contract, including the following key findings:

- ***Lack of Oversight:*** The DHS has no internal audit function to ensure that the EDS is complying with the terms of the contract and that the MMIS is operating as intended.
- ***Expenditure Information Not Provided:*** DOF budget staff were not provided timely or adequate information about expenditures being made for modifications (changes) authorized by the DHS for the MMIS. The DHS did not specifically track the cost to the state of these changes and therefore, the state had no method for determining whether these modifications were indeed cost-effective.
- ***No Payment Resolution Process:*** In the event the EDS disagreed with the amount paid to it by the state for its services, there were no procedures in place to resolve disputes with the contractor.
- ***State Information Technology Processes Sidestepped:*** The DHS incorporated information technology systems with little connection to the Medi-Cal Program into EDS' Medi-Cal contract to sidestep normal information technology development and procurement procedures. The DHS also circumvented the competitive procurement process without explicitly obtaining an exemption, making it difficult to ensure that that state received the best value for the development of these systems.

Prior Subcommittee Action (April 12th Hearing): The Subcommittee discussed the oversight of the EDS Fiscal Intermediary contract at length and heard from the LAO on their analysis of the various concerns raised. As such the Subcommittee adopted **Supplemental Reporting Language,** as recommended by the LAO, directing the DHS to develop and submit a corrective action plan to the DOF and the Legislature, and submit reports to both entities every six **months** commencing July 1, 2004. **This language is as follows:**

> "It is the intent of the Legislature that the DHS develop and submit a corrective action plan to the DOF Office of State Audits and Evaluations and to the Legislature that identifies the actions it plans to take toward implementing the recommendations described in the report entitled, "Final Audit Report—Examination of the Department of Health Services Fiscal Intermediary Contract with Electronic Data Systems for Medi-Cal Claims Processing." **It is also the intent of the Legislature that on October 1, 2004, and April 1, 2005, that DHS submit semiannual reports to the Office of State Audits and Evaluations and to the Legislature regarding its progress towards implementation of the audit recommendations.** The legislative reports shall be provided in writing to the Chairs of all of the fiscal committees of both houses of the Legislature.

In addition, the Subcommittee eliminated a $100,000 (total funds) appropriation for the Fiscal Intermediary contract as contained in the Governor's January budget for "unspecified change orders", and reduced the Medi-Cal Dental Fiscal Intermediary appropriation by $50,000 (total funds) for the same reason (unspecified change orders).

Governor's May Revision: The May Revision **proposes an increase of $590,000 ($194,000 General Fund) to (1) establish four positions-- three permanent and one two-year, limited-term--, and (2) purchase computer software and equipment to develop an automated invoice tracking/cost monitoring system.** This request for resources is in response to the DOF evaluation, as noted above.

Specifically, this request includes the following:

- Two Associate Administrative Analysts to perform additional detailed analysis and to track costs in the manner recommended in the DOF audit;
- Two Health Program Auditor IV positions to perform continuous financial and performance oversight of the Fiscal Intermediary contract;
- $87,000 to contract for the design and development of a new database accounting system;
- $61, 000 to enter into a separate interagency agreement with the DOF to conduct a follow-up audit of the Fiscal Intermediary contract;
- $61,000 to enter into an interagency agreement with the DOF to develop and maintain an information technology framework for projects implemented via the Fiscal Intermediary contract.

Legislative Analyst's Office Comment: Based on their review**, the LAO recommends to reject all of the requested positions and all of the requested funding. The LAO noted the following:**

- The department already has sufficient staff in the view of the LAO to provide adequate oversight of the contract and to address the DOF concerns.

- If necessary, to improve its oversight of the EDS contract, the department may need to closely evaluate the responsibilities of existing staff and reprioritize workload to achieve its goal of implementing the audit's recommendations.
- The DHS currently uses a spreadsheet for tracking system contract costs.
- The first DOF audit was paid for out of the DHS' existing resources. The LAO believes that the cost for this second audit should also be paid out of the department's existing resources.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the LAO analysis. Therefore, it is recommended to reject the May Revision.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please briefly present the May Revision.**

Budget Issue: Does the Subcommittee want to adopt the **LAO recommendation to reject this May Revision request?**

15. Governor's Proposed Elimination of WARP

Background: Through the **Budget Act of 2001** and accompanying trailer bill legislation, an appropriation was provided to serve as a supplemental wage adjustment for long-term care facilities which have a collective bargaining agreement or contract to increase salaries, wages, or benefits for certain staff. Under this proposal, participating providers needed to provide proof of a binding written commitment and a method of enforcement of the commitment. **The program was intended to terminate when the DHS implemented a facility-specific reimbursement methodology for non-hospital based nursing facilities (i.e., freestanding facilities).**

It should be noted that the Supplemental Wage Payment has *never* been allocated to the facilities. The DHS did provide instructions to eligible facilities on October 3, 2003 (See Hand Out for cover letter). **However, these instructions were later abruptly rescinded because stakeholder groups notified the DHS of issues that required amendments to the instructions, and then shortly thereafter, Governor Schwarzenegger issued an Executive Order requiring state agencies to cease processing regulations. Further, the Governor proposed to eliminate this program as part of his Mid-Year Reduction proposals.**

It should be noted that Section 14110.65 of Welfare and Institutions Code which implements this program is slated to become inoperative as of August 1, 2004.

Governor's January Budget: **The budget proposes to eliminate funding for this adjustment for savings of $92 million ($46 million General Fund).**

Prior Subcommittee Hearing (May 3rd): The Subcommittee discussed this issue and received testimony. The issue was held open pending receipt of the Governor's May Revision.

Governor's May Revision: **The May Revision assumes elimination of this funding for the current year.** This is the **same proposal as contained in the Governor's January Budget.**

Budget Issue: Does the **Subcommittee want to restore or adopt the Governor's proposal to eliminate?**

D. Item 4260 Department of Health Services (*Discussion Items-continued*)

PUBLIC HEALTH ISSUES

1. California Children's Services Program—*Several Issues*

Overall Background on CCS: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially **eligible children with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence**. **The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.**

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. **By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.**

CCS enrollment consists of children enrolled as: (1) CCS-only (not eligible for Medi-Cal or the Healthy Families Program), **(2)** CCS and Medi-Cal eligible, and **(3)** CCS and Healthy Families eligible. **Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as county funds.**

Background on CCS Carve Out: During the 1990's, as California began enrolling increasing numbers of Medi-Cal recipients, including children, into managed health care plans, health experts and advocates became concerned that CCS-eligible children would not obtain appropriate, specialized health care services, particularly those children with significant medical needs. **As a result, in 1994 a "carve-out" for CCS-eligible children who are enrolled in Medi-Cal Managed Care**, became law, requiring these children to continue receiving highly specialized care for their CCS-eligible condition through CCS, while receiving preventive and general care through a managed care plan. **County Organized Health Systems (COHS) currently are the only plans that have CCS-eligible children and their needed services incorporated into their systems. Existing statute contains a sunset of August 1, 2005. The sunset has been extended twice before.**

The statute which created the carve-out also authorized the DHS to approve, implement, and evaluate limited pilot projects to test alternative managed care models tailored to the special healthcare needs of children under the CCS Program. The law requires the DHS to submit an evaluation to the Legislature of any pilot program. **To date, no pilot programs have been implemented and therefore, no evaluation has been completed.**

Prior Subcommittee Action (March 8th): In this hearing, the Subcommittee discussed several core issues regarding the CCS Program—**(1)** the Governor's proposed cap on enrollment, **(2)** drug rebates for blood factor products as well as potentially other items, such as medical supplies

and durable medical equipment, and **(3)** the Governor's proposed additional 10 percent rate reduction.

The Subcommittee took action to (1) reject the Governor's cap on enrollment, and (2) recognize $2.5 million (General Fund) savings by proceeding with obtaining rebates for various drug products and contract savings.

Governor's May Revision: The **May Revision proposes total program expenditures of $220.5 million ($82.5 million General Fund, $75.3 million County Realignment Funds**, **$51.1 million federal Title XXI funds,** $11.1 million federal Maternal & Child Health block grant funds, and $500,000 patient enrollment fees). **The Governor has conformed to the Senate action by eliminating his enrollment cap proposal as contained in his January Budget. In addition, the proposed additional rate reduction of 10 percent has been removed as well.** The May Revision does include a five percent rate reduction as adopted in the Budget Act of 2003.

Subcommittee Staff Comments and Recommendation: **First, it is recommended for the Subcommittee to adopt the CCS Program baseline estimate** (caseload, rate reimbursement levels and related expenditures) since the Governor conformed with the Legislation in not proceeding with caps or with an additional 10 percent rate reduction**.**

Second, it is recommended for the Subcommittee to retain the $2.5 million in General Fund savings through the collection of drug rebate funds and implementation of other contract savings, such as medical supplies and durable medical equipment (as was proposed in the Budget Act of 2003 and discussed at the March 8th hearing). The DHS was provided with three positions last year to address this issue. (This savings figure was based on the fact that the CCS Program provides over $130 million in direct services annually and that 30 percent of these services are for such items as medical supplies, durable medical equipment and blood factor product).

Third, **it is recommended to adopt trailer bill language to extend the sunset date for the carve out to September 1, 2008. This would provide for a three-year extension.** It is further recommended to make a technical change to the statute to clarify the name of the Santa Barbara Regional Health Authority. **It should be noted that the proposed language does not address any issues related to the expansion of Medi-Cal Managed Care.** This issue can, if desired, be more thoroughly discussed in August, when the Administration presents their discourse and information regarding their proposed Medi-Cal Program Redesign.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please provide a brief summary of the Governor's May Revision.

Budget Issue: Does the **Subcommittee want to (1)** adopt the Governor's May Revision, **(2)** retain the $2.5 million (General Fund) in savings by achieving more drug rebate and contract savings as done in the March 8th hearing, and **(3)** adopt trailer bill language as outlined to extend the sunset by three years and make a clarifying amendment regarding Santa Barbara?

2. Genetically Handicapped Persons Program (GHPP)—*Several Issues*

Overall Background: The GHPP **provides diagnostic evaluations, treatment services, and medical case management services for adults with certain genetic diseases**, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, and certain neurological metabolic diseases. **The services covered by the GHPP include all the medically necessary medical and dental services needed by the client, not just the services related to the GHPP-eligible condition. (GHPP differs from the California Children's Services (CCS) Program in that CCS covers only services related to the CCS eligible condition.)**

GHPP is suppose to be the "payer of last resort" (as a 100 percent General Fund program) meaning that third-party health insurance and Medi-Cal coverage are to be used first. GHPP authorized services are **reimbursed according to the following guidelines** established by the DHS:

- **For GHPP-only clients** (non-Medi-Cal eligible) **with no health insurance**, GHPP reimburses providers using **solely General Fund support at Medi-Cal fee-for-service rates with claims adjudicated through EDS (state's fiscal intermediary);**
- GHPP clients with health insurance are required to use their health insurance first before GHPP state support is used. **Providers are to bill third-party health insurance first for these clients;**
- **Medi-Cal clients enrolled in GHPP may be enrolled in Medi-Cal Managed Care plans *or* be in fee-for-service Medi-Cal and are provided assistance as follows:**
- **Managed care Medi-Cal clients** are only eligible for GHPP special care center team assessment and evaluation services which are reimbursed fee-for-services. All other benefits are covered by the health plans under the managed care arrangement.
- Fee-for-service Medi-Cal clients have services paid by Medi-Cal but are case managed by GHPP.

DHS Notes Substantial Cost Increases Over Past Years: **Expenditures for the GHPP have been rapidly increasing over several years.** In fact, the program **increased well over 340 percent from 1996 to 2004** (from $12 million General Fund to **$53 million General Fund).**

Prior Subcommittee Action (March 8th): In this hearing, the Subcommittee discussed several core issues—(1) the Governor's proposed cap on enrollment for the program, (2) the Governor's proposed co-payment for enrollees, (3) the drug factor rebates owed to California from the 2002-03 fiscal year, and (4) contract rebate savings and related cost containment measures.

The Subcommittee took action to (1) reject the Governor's cap on enrollment, **(2)** adopted trailer bill legislation to establish a special fund for the collection of GHPP and CCS rebates, **(3)** appropriated the $4.1 million in identified rebates from 2002 for the GHPP (owed to the state by specified manufacturers), **(4)** used $89,000 (collected drug rebates funds) of the identified drug rebates for a new Associate Governmental Program Analyst position to assist with the various functions for cost containment, and use the remaining amount to offset General Fund in 2004-05, **(5)** recognized increased savings of $5 million (General Fund) for contracts, pharmaceutical rebates, medical supplies and related items, above the Administration's January Budget proposal of only $1.5 million (General Fund).

Governor's May Revision: The **May Revision proposes total expenditures of $52.9 million** ($52.8 million General Fund and $200,000 in Fees). **The Governor has conformed to the Subcommittee's action by eliminating his enrollment cap proposal as contained in his January Budget. In addition, the proposed additional rate reduction of 10 percent has been removed, and the Administration has eliminated their proposal to implement a new co-payment provision.** The May Revision does include a five percent rate reduction as adopted in the Budget Act of 2003.

Subcommittee Staff Comment and Recommendation: It is recommended to **(1)** adopt the Governor's May Revision, **(2)** retain the $5 million in additional rebates, to offset General Fund moneys, for contracts, and drug rebates as done in the March 8th hearing, **(3)** retain the trailer bill language to establish a special fund for the collection of GHPP and CCS rebates as done in the March 8th hearing, **and (4)** retain the action to use $89,000 (drug rebates) for a new Associate Governmental Program Analyst position to assist with the various functions of cost containment

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please provide a brief summary of the Governor's May Revision.
- **2.** Please provide an update on the blood factor rebates.

Budget Issue: Does the Subcommittee want to adopt the above Subcommittee staff recommendation?

3. Proposition 99 Funded Programs

Overall Background—General : Proposition 99, the Tobacco Tax and Health Protection Act of 1988, established a surtax of 25 cents per package on cigarettes and other tobacco products, and provided a major new funding source for health education, indigent health care services, and resources programs.

Under the provisions of Proposition 99, **revenues are allocated across six accounts based on specified percentages. These are**: **(1)** Health Education Account—20 percent, **(2)** Hospital Services Account—35 percent, **(3)** Physician Services Account—10 percent, **(4)** Research Account—5 percent, **(5)** Unallocated Account—25 percent, and **(6)** Public Resources Account—5 percent (discussed in Subcommittee No. 2).

Governor's May Revision—Revenues: Proposition 99 **revenues are projected to increase slightly to be a total of $334.5 million in May for all accounts. It should also be noted that, as required by Proposition 10, the State Board of Equalization transferred as necessary to offset the loss in revenue to the Health Education and Research accounts.**

Governor's May Revision—Expenditures: The May Revision makes a series of small adjustments due to the increase in revenues. **These are discussed below.**

Health Education Account Programs:

- Provides $3.6 million for the DHS Tobacco Education and Research Oversight.
- Provides **$15.7 million for the Media Campaign**
- Provides **$15.4 million for Competitive Grants**
- Provides **$16.2 million for Local Lead Agencies**

Health Care Programs (Hospital Services, Physicians', & Unallocated Accounts):

- Provides **$392,000 for Children's Hospitals.**
- Provides **$6.8 million for EAPC Clinics.**
- Provides **$45.3 million for the CA Healthcare for Indigents Persons Program**, of which **$22.3 million is for uncompensated hospital emergency services.**
- Provides **$4.7 million for Rural Health Services.**
- Provides **$11.3 million for the Breast Cancer Early Detection Program.**
- Provides **$4.4 million for DHS administration of various programs.**

Budget Issue: Does the **Subcommittee want to approve as proposed in the May Revision?**

4. Radiation Control Fund---Issue of Solvency

Background—Radiation Control Program: This program area covers (1) mammography certification and inspection activities, (2) enforcement and compliance activities related to radioactive material and radiation machine inspections, and (3) assists in a wide variety of other radiologic health functions.

In the Governor's January Budget, the DHS budget for this program showed expenditures and revenues of $18.1 million (Radiation Control Fund). Information received by the Subcommittee noted that the expenditures were for 118 staff *plus* other expenditures.

These other expenditures included (1) *$6.1 million* (Radiation Control Fund) *for operating expenses, and (2) $2.9 million for "distributed" costs*. The following breaks down these line items:

• General Expense	$1.1 million (6 percent of the total)
• Printing and Postage	$116,000
• Travel In State	$737,000
• Equipment	$360,000
• Technical Scientific Items	$67,000
• Travel Out of State	$142,000
• External Contracts	$3.3 million

- Internal Contracts $121,000
- Distributed Facility Operations $968,000
- Distributed Data Processing $577,000
- Distributed Administration $768,000
- Distributed Program OH $390,000

Prior Subcommittee Hearing (May 10th): In this hearing, the Subcommittee requested to receive a more detailed break down of these expenditures. **This information has *not yet* been provided. Further, it was unclear at the time of the hearing what level of revenue collection from fees would be obtained.**

Governor's May Revision—Proposes Questionable Budget Bill Language: The May Revision proposes Budget Bill Language to reduce expenditures to be more in line with revenues. **However, it is unknown at this time what programmatic affect reductions will have because no detail has been forthcoming on what would actually be reduced and its potential affect on the citizens of California. The proposed May Revision language is as follows:**

> "Of the amount appropriated in this Item, $6,050,000 shall not be available for expenditure on the Radiologic Control Program, except to the extent that fee revenues above the $12 million that is currently projected for 2004-05 are deposited in the Fund."

Subcommittee Staff Comment and Recommendation: No information has been provided as requested in the May 10th Subcommittee hearing, and no details on what would, or would not, be reduced has been provided. **As such it is recommended to reject this proposal.**

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to respond to the following questions:

- **1.** Please describe the May Revision proposal.
- **2.** Specifically, what services will not be provided?
- **3.** Why is there a problem here—is it revenues or over expenditures?
- **4.** When will the Subcommittee receive the requested information from the May 10th hearing?

Budget Issue: Does the Subcommittee **want to reject this proposal?**